

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE	STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020
STATE LICENSE NUMBER: 110902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0625 SS=D	Based on a Medicare/Medicaid Recertification, State Licensure, Civil Rights survey and a complaint survey completed on April 23, 2025, it was determined that Transitions Healthcare Allens Cove was not in compliance with the following requirements of 42 CFR Part 483 Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0625		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0625 SS=D	Continued from page 1 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	1. An audit will be conducted on past discharged residents to identify past deficient practice. 2. Any current residents moving forward will have a bed hold policy signed by resident or documentation on bed hold policy that the policy was explained to resident. 3. A copy of the bed hold policy as well as the bed hold agreement will be placed in a binder at the nurse's station. If a resident must be transferred the facility form will be completed in person or via phone if required with the original provided to patient or responsible party and a copy to remain in the chart. 4. DON or designee will provide education to nursing staff on the proper procedure for issuing the bed hold notice. 5. DON or designee will audit all transfers three times weekly x 4 weeks, the two times monthly x 2 months to ensure that the proper	Completion Date: 06/03/2025 Status: APPROVED Date: 05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902	STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
--------------------	--	---------------	--	--------------------

F 0625 SS=D	Continued from page 2	F 0625	bed hold policy is initiated and executed. Results will be taken to the QAPI committee for review of findings and further interventions if warranted.	
--------------------	-----------------------	--------	---	--

--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0625 SS=D	Continued from page 3 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for one of three residents reviewed for hospitalization (Resident 45). Findings Include: Review of facility policy, titled "Bed Holds and Returns and Therapeutic Leave of Absence", last dated January 3, 2024, revealed "The Facility is required to provide a bed hold under certain circumstances and make the Resident aware of the Facility's bed hold and return policy as related to hospitalization and therapeutic leave. The facility will provide information on bed hold requirements to all residents upon admission and again at time of transfer from the Facility. Bed Hold requirements will be included in the Facility Admission packet to be reviewed during the admission process and will be considered the first notice of the Facility Bed	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0625 SS=D	<p>Continued from page 4</p> <p>Holds and Returns policy...The second notice, which details the duration of the bed hold policy, will be issued at the time of transfer. In cases of emergency transfer, notice 'at the time of transfer' means that the family, surrogate, or representative are provided with written notification within 24 hours of the transfer. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital."</p> <p>Review of Resident 45's clinical record revealed diagnoses that included hypertension (high blood pressure) and Type 1 Diabetes Mellitus (a lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels).</p> <p>Further review of Resident 45's clinical record revealed that she was transferred and admitted to the hospital on February 22, 2025, and March 15, 2025.</p> <p>During an interview with the Nursing Home Administrator on April 23, 2025, at 10:19 AM, it</p>	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0625 SS=D	Continued from page 5 was revealed that there is no evidence that Resident 45 and/or her Representative were provided with a written notice of the facility's bed hold notice at the time of either hospitalization. 28 Pa. Code 201.14(a) Responsibility of licensee	F 0625		
F 0641 SS=D		F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 6 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	<ol style="list-style-type: none"> 1. R9 and R32 MDS were corrected with accurate coding and resubmitted with modifications. 2. The regional care manager will complete education with the Licensed Practical Nurse Assessment Coordinator on accurate coding of identified sections of MDS per RAI guidelines and appropriate coding with emphasis on accurate coding. 3. An initial audit of MDS's will be completed for the past 30 days on identified residents. The Licensed Practical Nurse Assessment Coordinator will complete all assessments. 4. Licensed Practical Nurse Assessment Coordinator / Designee will complete an audit of 5 resident MDS submissions weekly x 4 weeks, then 5 resident MDS submissions two times monthly x 2 months. 5. When MDS is ready for submission the Licensed Practical 	<p>Completion Date: 06/03/2025</p> <p>Status: APPROVED</p> <p>Date: 05/05/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 7	F 0641	Nurse Assessment Coordinator will coordinate with the RN to verify accuracy of MDS prior to submission. 6. The results of the audit will be taken to the QAPI committee for review of findings and further interventions if warranted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641 SS=D	<p>Continued from page 8</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for two of 19 residents reviewed (Residents 9 and 32).</p> <p>Findings Include:</p> <p>Review of Resident 9's clinical record revealed diagnoses that included Multiple Sclerosis (MS - a disease that causes breakdown of the protective covering of nerves; can cause numbness, weakness, trouble walking, vision changes, and other symptoms) and neurogenic bladder (bladder dysfunction caused by nervous system conditions).</p> <p>Review of Resident 9's physician orders revealed an order dated June 28, 2024, for a Foley catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine; also known as an indwelling catheter).</p> <p>Review of Resident 9's Quarterly MDS (Minimum</p>	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641 SS=D	<p>Continued from page 9</p> <p>Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental, or psychosocial needs) dated February 16, 2025, revealed in section H, it was coded that Resident 9 had an indwelling catheter and was also occasionally incontinent of urine.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 23, 2025, at 10:45 AM, the DON confirmed that the MDS was coded in error, as Resident 9 was not occasionally incontinent of urine due to her Foley catheter.</p> <p>Review of Resident 32's clinical record revealed diagnoses that included heart failure (a condition where the heart cannot pump enough blood to meet the body's needs) and chronic kidney disease (a progressive condition where the kidneys gradually lose their ability to filter waste and excess fluid from the blood).</p> <p>Review of Resident 32's clinical record revealed she</p>	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 10 had an unwitnessed fall on March 2, 2025, at 2:00 AM, which resulted in an abrasion on the left thigh. Review of Resident 32's Significant Change MDS dated March 18, 2025, revealed in section J, it was coded that Resident 32 has not had any falls since admission/entry or reentry or prior assessment. During an interview with the NHA and DON on April 23, 2025, at 10:03 AM, the DON confirmed that the MDS was coded in error, as Resident 32's fall on March 2, 2025, should have been reflected. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0641		
F 0677 SS=D		F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902	STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0677 SS=D	Continued from page 11 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	<ol style="list-style-type: none"> 1. Facility cannot edit old documentation errors. 2. Facility will audit ADL care for dependent residents with regards to hygiene and bathing to identify any baseline opportunities for missed documentation or incorrect documentation. 3. DON or designee will provide education to the nursing staff on reviewing the ADL coding report prior to end of shift to ensure completion and accuracy of hygiene and bathing (showers) and address concerns prior to end of shift. 4. DON or designee will provide education to nursing staff regarding ADL coding and accuracy of coding in regard to hygiene and bathing. 5. Nursing staff will run an ADL coding report prior to end of all shifts with regards to bathing and hygiene (showers) to ensure showers are given and if resident is refusing what other alternatives were 	Completion Date: 06/03/2025 Status: APPROVED Date: 05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902			STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE	
F 0677 SS=D	Continued from page 12	F 0677	<p>offered (bed bath).</p> <p>4. An audit will be conducted by DON or designee three times weekly x 4 weeks, then two times monthly x 2 months for ADL coding for dependent residents with regards to hygiene and bathing.</p> <p>5. Results of the audit will be taken to the QAPI committee for review of findings and further interventions if warranted.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0677 SS=D	Continued from page 13 Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure a resident who is unable to carry out activities of daily living (ADLs) receives the necessary services to maintain good grooming and personal hygiene for one of two residents reviewed for ADLs (Resident 23). Findings Include: Review of the facility policy, titled "Activities of Daily Living" last reviewed May 31, 2024, read, in part, "Residents will gain and/or maintain as much independence as possible in ADLs which are essential to the individual's lifestyle. This refers to activities an individual performs on a regular basis, such as eating, dressing, hygiene (make-up, shaving, washing), transfers, reading, writing, housework, smoking, walking, and even driving. The resident's performance may vary depending on the time of day, how the resident feels, setting, and the person with him/her."	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0677 SS=D	<p>Continued from page 14</p> <p>Review of Resident 23's clinical record revealed diagnoses that included spinal stenosis (a condition that narrows the space in the spine, putting pressure on the spinal cord or nerves), repeated falls, and muscle weakness.</p> <p>During an interview with Resident 23 on April 21, 2025, at 10:22 AM, she revealed she has sometimes not received a shower for over two weeks at a time, and recently did not receive a shower for eight days.</p> <p>Review of Resident 23's clinical record revealed she has a preferred shower schedule of Wednesday and Saturday on the 2-10 shift.</p> <p>Review of Resident 23's nurse aide task for showers revealed she did not receive a shower per her preferred schedule on January 8 and 11, 2025; February 5, 15, 22, and 26, 2025; March 1, 5, and 15, 2025; and April 16, and 19, 2025.</p> <p>During an interview with the Nursing Home</p>	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0677 SS=D	Continued from page 15 Administrator on April 22, 2025, at 2:15 PM, he revealed sometimes Resident 23 refuses to get out of bed for the staff during her shower days. Further review of Resident 23's clinical record failed to revealed notation to indicate she refused to get out of bed or was reapproached for a shower at a later time on the aforementioned days. Interview with the Director of Nursing on April 23, 2025, at 10:41 AM, revealed he would expect staff to document refusal of showers and reapproach residents at a later day or time who refused a shower as per their preferred schedule. 28 Pa Code 211.12(c)(d)(1)(3)(5) Nursing services	F 0677		
F 0684 SS=D		F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 16 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	<ol style="list-style-type: none"> 1. R24's yearly pacemaker appointment has been scheduled. 2. Facility will audit pacemaker orders and appointments on other residents to identify any baseline opportunities for missed pacemaker checks and/or annual appointments. 3. A Binder will be kept at the nurse's station with all residents that have pacemakers to ensure yearly appointments and regular checks are not missed going forward. 4. DON or designee will provide education to nursing staff on reviewing all pacemaker orders to ensure they are entered correctly, and appointments are made accordingly. 5. An audit will be conducted by DON or designee monthly x 3 months on all cardiac pacemakers to ensure remote checks are taking place and that yearly appointments are made. 	Completion Date: 06/03/2025 Status: APPROVED Date: 05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902			STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE	
F 0684 SS=D	Continued from page 17	F 0684	6.Results of the audit will be taken to the QAPI committee for review of findings and further interventions if warranted.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 18 Based on clinical record review, observation, and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for one of one of 16 residents reviewed (Resident 24). Findings include: Review of Resident 24's clinical record revealed diagnoses that included Alzheimer's disease (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), atrioventricular heart block (a type of heart block that occurs when the electrical signal traveling from the atria, or the upper chambers of the heart, to ventricles, or the lower chambers of the heart, is impaired), and presence of a cardiac pacemaker. Observation of Resident 24 on April 21, 2025, at 10:02 AM, revealed the presence of a Merlin at	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 19 Home (a remote telephonic pacemaker check device) on her bedside stand. Review of Resident 24's current physician orders failed to reveal any orders for a cardiology consult or pacemaker checks. Review of Resident 24's physician order history revealed an order for a yearly cardiology appointment on November 29, 2024, with a completion date of November 30, 2023; and an order for pacemaker check in 3 months by remote monitoring, with a completion date of January 25, 2023. Review of Resident 24's care plan revealed a care plan focus for a pacemaker with an intervention for pacemaker checks as ordered by cardiology and document in chart: Heart rate, Rhythm, Battery check, with a last revision date of July 7, 2022. Review of Resident 24's clinical record revealed that her last pacemaker remote check was completed on	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 20 September 18, 2024. During a staff interview the Director of Nursing (DON) on April 23, 2025, at 9:19 AM, the DON indicated that, after being made aware of the concern regarding Resident 24's cardiology and pacemaker testing was shared, that he began to investigate. The DON indicated that Resident 24 should have a yearly cardiology appointment and would have been due for an appointment in November 2024 or December 2024. The DON indicated that the cardiology office did not call to set up the yearly appointment as was their typical practice. The DON said when he called the cardiology office yesterday and they indicated that they had sent letters in November 2024 and December 2024 to a local address that they had on file for Resident 24, which was not the facility address. He said that the office said since they did not receive a response to the letters, they dropped it. The DON indicated that the cardiology office indicated that the pacemaker was still transmitting, and they would notify the emergency contacts if	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684 SS=D	Continued from page 21 there was an issue; however, they did not have the facility listed as the primary contact. The DON confirmed that Resident 24 has a cardiology office appointment the following week, and that the three-month remote pacer checks will be scheduled at that time. He also indicated that he had once again notified the cardiology office that Resident 24 plans to permanently reside at the facility. During a final staff interview with the Nursing Home Administrator and DON on April 23, 2025, at 10:53 AM, the DON confirmed that facility staff should have followed up and made sure Resident 24 had her annual cardiology appointment and remote pacemaker checks when the cardiology office did not follow up with the facility. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services	F 0684		
F 0688 SS=D		F 0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0688 SS=D	Continued from page 22 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	1. The facility cannot address past missed RNP programs. 2. Therapy department will do a baseline assessment for any adverse reactions from not receiving the RNP for resident 29 3. Facility will audit residents on a restorative nursing program to identify any baseline opportunities for missed RNP on residents. 4. DON or designee will provide education to nursing staff on providing restorative care as documented in the restorative nursing program. 5. An audit will be conducted by DON or designee on 5 random residents with RNP's weekly x 4 weeks, then 5 random residents with RNP's monthly x 2 months to ensure that all restorative nursing programs are documented as completed. 6. Results of the audit will be taken to the QAPI committee for review of	Completion Date: 06/03/2025 Status: APPROVED Date: 05/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902			STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE	
F 0688 SS=D	Continued from page 23	F 0688	findings and further interventions if warranted.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0688 SS=D	Continued from page 24 Based on review of clinical records and staff interviews, it was determined that the facility failed to provide restorative nursing care for range of motion exercises for one of three residents reviewed for position and mobility (Resident 29). Findings include: Review of Resident 29's clinical record revealed diagnoses that included peripheral vascular disease (a slow and progressive circulation disorder) and hypertension (high blood pressure). Review of Resident 29's clinical record revealed a Restorative Program Progress Note written on February 24, 2025, at 12: 17 PM, that read, in part, restorative nursing programs from passive range of motion (PROM) of right upper extremity (RUE) and right lower extremity (RLE) and active range of motion (AROM) of left lower extremity (LLE) continue. Resident 29 has a diagnosis of flaccid hemiplegia to right side; she is able to tolerate both PROM programs to right upper and lower	F 0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0688 SS=D	<p>Continued from page 25</p> <p>extremities and continues to participate and complete three sets of ten reps for each of the exercises listed within the AROM LLE programs.</p> <p>Review of Resident 29's clinical record revealed a restorative nursing program task for AROM of LLE for 15 minutes twice daily. Further review of the documentation for restorative nursing revealed that for April 2025, there were 13 days where restorative nursing was not completed twice a day or was marked as "not applicable".</p> <p>Review of Resident 29's clinical record revealed a restorative nursing program task for PROM of RLE for 15 minutes twice daily. Further review of the documentation for restorative nursing revealed that for April 2025, there were 13 days where restorative nursing was not completed twice a day or was marked as "not applicable".</p> <p>Review of Resident 29's clinical record revealed a restorative nursing program task for PROM of RUE for 15 minutes twice daily. Further review of the</p>	F 0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0688 SS=D	Continued from page 26 documentation for restorative nursing revealed that for April 2025, there were 12 days where restorative nursing was not completed twice a day or was marked as "not applicable". During an interview with the Nursing Home Administrator on April 23, 2025, at 10:35 AM, revealed that he would expect for Resident 29 to receive restorative nursing program services twice daily. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services	F 0688		
F 0761 SS=E		F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0761 SS=E	Continued from page 27 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	1. A new thermometer was purchased for the medication room refrigerator. 2. Medication room refrigerator was cleaned and defrosted. 3. DON or designee will provide education to nursing staff in regard to routine checking of temperatures and that all medication should be stored between 36 – 46 degrees. 4. An audit will be conducted by NHA or designee weekly x 4 weeks, then monthly x 2 months to ensure that all medications are stored between 36 – 46 degrees. 5. Results of the audit will be taken to the QAPI committee for review of findings and further interventions if warranted.	Completion Date: 06/03/2025 Status: APPROVED Date: 05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0761 SS=E	Continued from page 28 Based on facility policy review, observation, staff interview, and facility document review, it was determined that the facility failed to store medications under proper temperature controls in one of one medication rooms reviewed. Findings include: Review of facility policy, titled "Storage of Medications" with a last revised date of August 2020, and a last review date of May 2024, revealed the following: "II. Temperature 1. All medications are maintained within the temperature ranges noticed in the United States Pharmacopeia (USP) and by the Centers for Disease Control (CDC); c. Refrigerated: 36°F to 46°F (2°C to 8°C) with a thermometer to allow temperature monitoring; 2. Medications and biologicals are stored at their appropriate temperatures and humidity according to the USP guidelines for temperature ranges; 4. Medications requiring refrigeration are kept in a refrigerator at temperatures between 36°F (2°C) and 46°F (8°C) with a thermometer to allow	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0761 SS=E	Continued from page 29 temperature monitoring; and 6. The facility should maintain a temperature log in the storage area to record temperatures at least once a day or in accordance with facility policy." Observation of the medication room refrigerator on April 22, 2025, at 9:06 AM, with Employee 2, revealed that the thermometer was sitting inside the small freezer portion of the refrigerator, which had approximately one inch of ice build-up and the temperature read 20 degrees Fahrenheit (F). Review of facility provided medication room refrigerator temperature log for April 2025 revealed the following: April 1 temperature was recorded as 18 degrees F; April 2 temperature was recorded as 34 degrees F; April 3 temperature was recorded as 32 degrees F; April 6 temperature was recorded as 34 degrees F; April 7 temperature was recorded as 34 degrees F; April 8-11 no temperatures were recorded; April 12 temperature was recorded as 34 degrees F; and	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0761 SS=E	Continued from page 30 April 13 temperature was recorded as 32 degrees F. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing on April 22, 2025, at 2:38 PM, the NHA indicated that he would expect medications to be stored at appropriate temperatures and that temperatures would be taken and recorded daily. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(c)(d)(2)(3) Nursing services	F 0761		
F 0812 SS=E		F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 31 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. All food not stored properly was discarded. 2. Dietary manager will provide education to dietary staff on proper storage of food, proper dishwasher temperatures and cleaning of kitchen equipment. 3. Facility has signed a lease for a new dishwasher on 5/1/25, looking to have installed in the next month. 4. Exhaust vent over top of dish machine was cleaned as well as dishwasher. 5. An audit will be performed on the exhaust vent two times weekly x 4 weeks, then monthly x 2 months. 5. An audit will be performed on the dish machine temperature log weekly x 4 weeks, then monthly x 2 months to ensure final rinse temperatures are above 180 degrees 3. An audit will be performed to make sure all food is being stored and	Completion Date: 06/03/2025 Status: APPROVED Date: 05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 32	F 0812	<p>dated properly in the pantry, walk in refrigerator, dry storage area and freezer three times weekly x 4 weeks, then two times monthly x 2 months.</p> <p>4. Dietary Manager going forward will have dietary aides perform a checklist for both AM and PM to ensure that the dish machine is cleaned inside and out as well as the vent above dish machine daily.</p> <p>4. Results will be taken to QAPI for review of findings and further interventions if warranted.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 33 Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to store food and utilize kitchen equipment in accordance with professional standards for food service safety in the main kitchen. Findings include: Review of facility policy, titled "Food Storage" last reviewed May 31, 2024, read, in part, "All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods. All containers or storage bags must be legible and accurately labeled and dated. All foods should be covered, labeled, and dated and routinely monitored to assure that foods will be consumed by their safe use by dates, or frozen (where applicable), or discarded." Observation in the dry storage area on April 21, 2025, at 10:03 AM, revealed four bags of white bread with a use by date of March 22, 2024, and six packs of English muffins not dated.	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	<p>Continued from page 34</p> <p>Observation of the dish machine in the main kitchen on April 21, 2025, at 10:07 AM, revealed it was heavily soiled with a brown substance on the top; further observation revealed a brown substance consistent with food debris was observed in the corners of the top of the dish machine.</p> <p>Observation of the exhaust vent over top of the dish machine in the main kitchen on April 21, 2025, at 10:08 AM, revealed it was soiled with a fuzzy black substance.</p> <p>Interview with Employee 4 (Dietary Manager) on April 21, 2025, at 10:08 AM, revealed she was unsure of where the substance on the dish machine was coming from, that a kitchen staff member had just wiped the entire machine down three days prior, and she was unsure about when maintenance staff had last cleaned the exhaust hood.</p> <p>Observation of the dish machine temperature log in the main kitchen on April 21, 2025, at 10:09 AM,</p>	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 35 revealed the record final rinse temperature was below the minimum safe temperature during breakfast on April 7, 10, and 20, 2025. Further observation of the log failed to reveal any corrective action noted on those days. Observation in the walk-in refrigerator on April 21, 2025, at 10:11 AM, revealed a tub of hard-boiled eggs that was dirty on the top and not properly sealed. Further observation of the tub revealed the eggs had a use by date of February 23, 2025. Observation in the main kitchen on April 21, 2025, at 10:14 AM, revealed one bag of white bread open with a half of a loaf left. Further observation of the bread revealed a use by date of March 11, 2025. Review of the March 2024 dish machine temperature log revealed the record final rinse temperature was below the minimum safe temperature during breakfast on March 22-24, 30, and 31; during lunch on March 12-14, 18, 20, 21, 24, and 27; and during dinner on March 1, 11-13,	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 36 15, 19, 20, 24, 25, 27, 29, and 30. Further observation of the log failed to reveal any corrective action noted on those days. Return visit to the kitchen on April 22, 2025, at 12:29 PM, revealed the dish machine remained dirty with a brown substance on the top and a brown substance consistent with food debris was observed in the corners of the top of the dish machine. Observation of the exhaust vent over top revealed it was soiled with a fuzzy black substance. Interview with Employee 4 on April 22, 2025, at 12:46 PM, revealed staff should be regularly cleaning kitchen equipment and surfaces daily, but that she does not have a routine cleaning schedule checklist for review. Follow-up interview with Employee 4 on April 22, 2025, at 12:54 PM, revealed she was unable to locate dish machine temperature logs from July 2024 to December 2024.	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 37 During an interview with the Nursing Home Administrator (NHA) on April 22, 2025, at 2:12 PM, the surveyor revealed the concern with food storage in the kitchen, as well as the dirty kitchen equipment, rinse temperature below safe minimum temperature on select days, and lack of dish machine temperature logs for review from July 2024 to December 2024. The NHA revealed his expectation that expired items are discarded, foods items are labeled and dated per facility policy, and food items and kitchen equipment are stored, cleaned, and utilized in accordance with professional standards. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.6(f) Dietary services	F 0812		
F 0880 SS=D		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=D	Continued from page 38 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1. DON will provide education to Employee 2 on infection control practices during medication administration to ensure all infection control procedures are being followed. 2. DON will provide education to Employee 2 on Enhanced Barrier precautions for gown and gloves when giving care to an individual on these precautions. 3. DON will provide education to Employee 2 on proper cleaning and disinfecting of glucometers after each use. 4. DON will provide education to nursing staff on infection control practices during medication passes Enhanced Barrier Precautions and proper glucometer disinfecting. 5. Resident's 9, 27 and 155 were all assessed for any adverse effects regarding nonadherence to infection control practices and enhanced barrier precautions.	Completion Date: 06/03/2025 Status: APPROVED Date: 05/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=D	Continued from page 39 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	6. All other residents on Employee 2's medication pass were assessed for any adverse reactions related to not following infection control practices and enhanced barrier precautions. 5. DON / designee will conduct an audit 2 times a week x 4 weeks on via direct observation of a medication pass, then monthly x 2 months. 6. All findings will be taken to QAPI for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902	STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=D	Continued from page 40	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=D	Continued from page 41 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to maintain an effective infection control program related to the preparation and administration of medications for three of three residents observed (Residents 9, 27, and 155). Findings include: Review of facility policy, titled "General Guidelines for Medication Administration" with a last revised date of August 2020, and a last review date of May 2024, revealed the following, "The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly: i. Before beginning a medication pass; ii. Prior to handling any medication; iii. After coming into direct contact with a resident" and "Hand sanitization is done with a facility approved sanitizer ii. At regular intervals during the medication pass such as after each room, again assuming handwashing is not indicated."	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=D	Continued from page 42 Review of facility policy, titled "Transitions Healthcare Allen's Cove IC-Infection Control Plan 2024" with a last revision date of September 1, 2024, revealed, "Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of MDRO's [multiple drug resistant organism] through gown and glove use by HCP [health care providers] in long-term care settings in accordance with the CDC [Centers for Disease Control] ...EBP are recommended during high contact care ...activities with residents who are at higher risk of acquiring or spreading an MDRO" such as "Residents with ...indwelling medical devices ...e[xample g[iven] central line (a catheter placed into a large vein used to administer medication or fluids)." Review of facility policy, titled "IC-519 Glucometer Cleaning, Disinfecting and Use" with a last revised date of October 1, 2017, and a last review date of May 2024, revealed, "1. All glucometers [device used to test blood sugar level] must be cleaned and disinfected after each use and between residents as	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=D	Continued from page 43 follows: a) Clean the outside of the glucometer with a damp cloth with soap and water or an alcohol swab to remove any visible blood or body fluids. b) Disinfect the meter using a pre-moistened germicidal disposable wipe (PDI)." During a medication pass observation on April 22, 2025, at approximately 8:30 AM, Employee 2 removed her gloves after administering an insulin injection to Resident 9, administered Resident 9 her oral medications, returned to the medication cart, and then began to prepare Resident 27's medications for administration. During the ongoing medication pass observation on April 22, 2025, at approximately 8:36 AM, Employee 2 entered Resident 27's room and was observed applying gloves to perform a blood glucose test. Resident 27 requested that the window be closed, and Employee 2 was observed using her gloved right hand to close the window and then proceeded to perform the glucose test. After completion of the test, Employee 2 returned to her	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=D	Continued from page 44 medication cart and wiped down the glucometer with an alcohol pad. She then wrapped the glucometer in an alcohol pad and placed it in a clear plastic cup on top of the medication cart. Employee 2 indicated that she was not sure how the glucometer was to be cleaned, but that this is how she does it. Employee 2 removed her gloves and began to prepare the rest of Resident 27's medications when she was notified that Resident 155's intravenous medication administration pump was beeping. Employee 2 then proceeded to Resident 155's room. Observation of Resident 155's room on April 22, 2025, at approximately 8:39 AM, revealed that an Enhanced Barrier Precautions (EBP) sign was posted outside the door to the room, which indicated that staff were to wash/cleanse hands before entering the room and that staff should wear gloves and gowns when caring for a central line. During the ongoing medication pass observation on April 22, 2025, at approximately 8:40 AM,	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=D	Continued from page 45 Employee 2 entered Resident 155's room without cleansing her hands, applied gloves, and flushed Resident 155's central line. Employee 2 then left the room and discarded intravenous fluid bag in the biohazard container in the dirty utility room. Employee 2 then cleansed her hands with hand sanitizer. This was the first observation of hand cleansing since medication pass observation began at 8:26 AM. During a medication pass observation on April 22, 2025, at approximately 8:46 AM, Employee 2 was observed to apply gloves in preparation of administering Resident 27 an insulin injection. Resident 27 requested that her trash can be moved closer to her chair. Employee 2 scooted the trash can across the floor with her feet, but when she got to Resident 27's chair, she used her gloved left hand to pick up the open top trash can and place it where Resident 27 requested. Employee 2 then proceeded to administer Resident 27's insulin injection wearing the same gloves. Employee 2 then removed her gloves and applied another pair of gloves to	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=D	Continued from page 46 administer Resident 27 her nasal spray and her oral medications. Employee 2 then removed her gloves and used hand sanitizer to cleanse her hands. During a staff interview with Employee 2 on April 22, 2025, at 9:06 AM, Employee 2 indicated that she should have cleansed her hands between residents, between glove changes, and that she thought she only needed to wear a gown for a resident on EBP if she was going to be in close contact. After reading the EBP posting, Employee 2 confirmed that she should have worn a gown when flushing Resident 155's central line. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 22, 2025, at 2:36 PM, the NHA and DON confirmed that they would expect staff to follow personal protective equipment guidance for EBP and to wash and/or cleanse hands when changing gloves, between residents, and after touching dirty items.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0880 SS=D	Continued from page 47 During a staff interview with the NHA on April 23, 2025, at 10:53 AM, the NHA confirmed that he would expect nursing staff to follow the facility glucometer cleaning policy. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28. Pa Code 211.12(c)(d)(1)(2)(5) Nursing services	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025	
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE STATE LICENSE NUMBER: 110902		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 1700	Prevention, control and surveillance of tuber (b) Recommendations of the Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services (HHS) shall be followed in screening, testing and surveillance for TB and in treating and managing persons with confirmed or suspected TB. This REGULATION is not met as evidenced by:	P 1700	<ol style="list-style-type: none"> 1. Facility policy has been reviewed and revised in accordance with state regulations. 2. Employee 1 has had a TB questionnaire completed and signs/symptoms were all negative. 3. Employee 1 had a T-Spot done. 3. NHA will provide education to HR Coordinator regarding TB testing completion before a candidate starts on their job duty assignment. 4. Baseline audit will be completed on employee files to determine compliance with TB screening. 5. NHA or designee will conduct an audit monthly x 2 months on all new hires to ensure all have proper TB documentation before the start date of employment. 6. Results of the audit will be taken to the QAPI committee for review of findings and further interventions if warranted. 	Completion Date: 06/03/2025 Status: APPROVED Date: 05/07/2025
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395915	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/23/2025
NAME OF PROVIDER OR SUPPLIER: TRANSITIONS HEALTHCARE ALLENS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE: 25 COVE ROAD DUNCANNON, PA 17020		
STATE LICENSE NUMBER: 110902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 1700	Continued from page 1 Based on review of personnel records, review of facility policy, and interviews with staff, it was determined that the facility failed to complete a TB (tuberculosis) test for one of five employees reviewed (Employee 1) Findings include: Review of facility policy, IM-162 Tuberculosis-Employee Screening, revised June 14, 2023, revealed, "Each newly hired employee will be screened for TB infection and disease after an employment offer has been made but prior to the employee's duty assignment." Review of Employee file for Employee 1 failed to reveal that Employee 1 had received any tuberculin screening "after an employment offer has been made but prior to the employee's duty assignment." Interview with the Nursing Home Administrator on April 23, 2025, at 11:30 AM, revealed that the process is currently being worked on.	P 1700		



Certified End Page

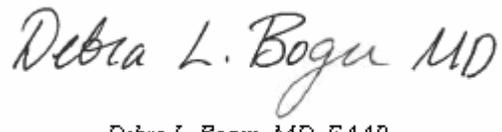
TRANSITIONS HEALTHCARE ALLENS COVE

STATE LICENSE NUMBER: 110902

SURVEY EXIT DATE: 04/23/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY