STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395414	A. Building B. Wing	04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Terrace View	108 Terrace Drive Olyphant, PA 18447

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 26861 Based on a review of the minutes from Residents' Council meetings, select facility policy and grievances, resident and staff interviews it was determined that the facility failed to provide care in a manner and environment, which promotes each resident's quality of life by failing to respond timely to residents' request for assistance as reported by 10 residents interviewed (Residents C1, C2, C3, C4, C5, C6, C7, C8, C9, C10) and failed to provide care to ensure one resident observed maintained a dignified personal appearance (Resident A1). Findings included: A review of the Resident Council Meeting minutes dated February 15, 2022, revealed that residents in attendance were asked if their call bells are answered timely to which the residents responded, yes. Review of the March 23, 2022, Resident Council Meeting minutes, revealed that the residents in attendance at the meeting expressed concerns that agency nursing staff are not answering their call bells in a timely manner, at various times, during all shifts of nursing duty. Review of the April 19, 2022, meeting minutes revealed that the question of timely call bell response was not addressed with the residents. During an interview with Resident C1, (Resident Council President) on April 27, 2022, at 11:40 AM, Resident C1 confirmed that the facility asks residents, each monthly resident meeting, if their call bells are answered timely. Resident C1 stated that she was unsure why it was not noted in the written meeting minutes for the April meeting. Resident C1 stated that the Activity Director types the minutes after each Resident Council meeting. Resident C1 verified that other residents at the April 2022 meeting had in fact expressed concerns that their call bells are not answered timely and the problem as stated during the March 23, 2022, meeting continued to be a concern. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the days of the survey April 27, 2022, and April 28, 2022, interviews were conducted with residents (Residents C2, C3, C4, C5, C6, C7 and C8) who were in attendance at the April 19, 2022, Resident Council Meeting. The residents stated that untimely staff response to their call bells continues to be a problem for them as they often wait 20 minutes or more for a staff member to answer the call bell and provide needed assistance. The residents also stated that nursing staff will turn their call light off, and tell the residents they will return shortly, and fail to do so, or they tell the residents that they are short staffed and will have to wait longer. Resident C9 and C10 , who were not in attendance at the April 2022 Resident Council Meeting, were interviewed on April 28, 2022, at 9:45 AM. Both residents stated that staff frequently do not answer their call bells timely. The residents stated that they have waited 20 to 25 minutes for their call bell to be answered and their needs met. Review of the facility's policy entitled Call Light, Answering last reviewed by the facility December 7, 2021, indicated it is the policy of the facility to respond to the resident's requests and needs in a prompt, courteous manner. If you have promised the resident you will return with an item or information, do so promptly. According to the facility staff, promptly means within 10 minutes. An observation April 27, 2022 at approximately 10:30 AM, revealed Resident A1 seated in a wheelchair in the hallway of the nursing unit. The resident's pants were observed to be soiled with dried food and liquid stains and crumbs. The resident's hair was clean, but disheveled. An observation of Resident A1 on April 28, 2022 at approximately 1:30 PM, revealed the resident seated in a wheelchair in the hallway of the nursing unit. The resident's paints again were soiled with food and liquid stains and crumbs. The resident's hair was not combed and appeared disheveled. A review of beauty salon documentation indicated that the last time this resident visited the beautician was December 27, 2021, for a hair cut. During an interview on April 28, 2022, at 10:15 AM, the Nursing Home Administrator and the Director of Nursing were unable to provide evidence to demonstrate that the facility consistently provided care in a manner and environment that promoted each resident's quality of life and personal dignity. 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing Services 28 Pa. Code 201.29 (i)(j) Resident Rights 28 Pa. Code 201.18 (e)(1) Management

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26861 Based on observations and staff interview, it was determined that the facility failed to provide housekeeping services to maintain a clean and orderly resident environment and care equipment on four of four resident units (B2,C1, C2 and D unit) Findings include: Observations on April 27, 2022, unit B-2 at 8:30 AM revealed: Dirt and debris was observed on the floor of the hallway. The floor of the nurses station was stained with dried liquid spills. station In resident Room B-219, a vacant room at the time of the observation, revealed that upon entry to the room, a dried liquid spill and accumulated dirt and debris was observed under the the bed. Dried liquid spills and marks on the surface of the tables, paper napkins on the window ledge, crumbs and food debris littered the floor and tables in the dining area on the B2 unit. A second observation of the dining area on the B2 unit April 27, 2022, at 11:15 AM, revealed the areas as described above remained in the same condition as observed during 8:30 AM, but ants were now observed on the floor. A third observation of the dining area on April 28, 2022, at 8:07 AM, revealed the areas observed on April 27, 2022, were in the same condition and ants were observed again in the dining hall. Review of the facility Housekeeping Routine for B-2 revealed the nurse's station is to be cleaned at 6:10 AM, the dining room is to be cleaned at 10:00 AM and 1:30 PM, and resident rooms are to be cleaned from 6:30 AM to 8:00 AM, 9:15 AM to 10:00 AM, 10:30 AM to 12:00 PM, 1:00 PM to 1:30 PM. No schedules were provided of cleaning done after 2:00 PM. Interview with Employee 2, Director of Environmental Services, on April 27, 2022, at 8:07 AM indicated that staffing of the environmental services is a problem and that he was responsible for the areas identified above. Employee 2 confirmed that he did not clean them yesterday or today. He also confirmed the presence of ants in the B-2 dining hall. Observations made on Unit B2 throughout the day of the survey ending April 28, 2022, revealed the hallway floors were dirty and had wax build up. Crumbs were observed on the floor, debris near and around the piano and tabletops dirty in the dining area. Observations of the C2 nursing unit on April 27, 2022, at approximately 8:45 AM revealed debris and dirt was observed on the floors in the hallways. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident Room C2-271, revealed that the garbage can in the residents' bathroom was overfilled with garbage. There were 2 bed pans and a wash basin observed on the bathroom floor. Disposable medical gloves were observed on top of a Swiffer mop. Coffee spills were observed on the floor and the floor was sticky. Dirt, debris and spilled liquids were observed on the floor of resident Room C2-272. Dirt & debris was observed on the floor of resident Room C2-216 . A used cotton ball and blood-like stained alcohol pad was observed on the floor. Under the bottom of the bed there was a yellow stain on the floor. Observations of C2-216 revealed the bathroom shower caulking was cracked and dirty. [NAME] colored splatter was observed on the wall. The shower drain contained accumulated dried hair. Observations made April 28, 2022 at 10:30 AM on the dementia unit revealed in the small dining/activity room, the floor was sticky and dirty with food debris, food crumbs and liquid stains. The surfaces of the dining tables and multiple overbed tables were soiled and sticky with food and liquid spill stains. In a cabinet in the room was two pair of used plastic gloves, turned inside and a dirty paper towel in the cabinet. In resident room [ROOM NUMBER], the floor was littered with food and paper debris as well as liquid stains. There were several areas of a brown pasty fecal-like material on the toilet seat and on the floor around the toilet. The sink and the faucet was were dirty and dried film was observed covering the surface of the sink. An observation April 28, 2022 at 10:30 AM and April 29, 2022 at 1 PM, revealed Resident A1 was seated in a wheelchair in the hallway. The surface of the wheelchair seat was ripped and torn. The wheelchair was dirty with dried food debris and liquid stains on the seat, back, arm rests and the wheels. Interview with the Nursing Home Administrator on April 28, 2022, at approximately 2:30 PM confirmed the facility is to be maintained daily to provide a clean and sanitary environment for the residents. 28 Pa. Code 207.2(a) Administrator's Responsibility.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 26142 Based on review of clinical records, select facility policy, select employee personnel files, and information submitted by the facility and local Area Agency on Aging (AAA) and interview with facility staff and a representative of AAA it was determined that the facility failed to ensure that one resident out of 29 residents sampled (Resident A2) was free of neglect. Findings include: A review of facility policy titled Abuse Policy last reviewed by the facility January 2022, revealed that residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, mistreatment, neglect, exploitation, and misappropriation of property. Residents shall not be subjected to abuse by anyone, including but not limited to, staff, other residents, consultants, volunteers and staff from other agencies, family members or legal guardians, friends, or other individuals. Information dated April 28, 2022, revealed that the local county Area Agency on Aging (AAA) reported to the facility that they had received an allegation of resident abuse. Information dated April 28, 2022, submitted by the facility revealed that AAA representative notified the facility that they had received a report that Resident A2 had been accompanied to a physician's visit in the community by a facility staff member, Employee 9 (a temporary nurse aide) on April 26, 2022. While awaiting the appointment at the physician's office, the resident was overheard requesting, on multiple occasions to be taken to the bathroom by this facility staff member. These requests went unheeded, and the resident became incontinent of urine. The resident was not wearing any type of incontinency brief and it was reported a puddle of urine was visible beneath the resident's wheelchair. The facility reported that they had not been made aware of this incident by the staff member accompanying the resident and were not aware of the incident until they were notified by AAA. The facility stated they interviewed the resident and he confirmed these allegations. A review of Resident A2's most recent MDS Minimum Data Set Assessment (a federally mandated standardized assessment tool completed at various intervals to plan resident care) dated January 27, 2022, revealed that the resident was frequently incontinent of bowel and bladder and required the extensive assistance of two staff members with activities of daily living, including transfer and toileting. According to this assessment, the resident's BIMS score (brief interview for mental status - a tool to assess cognitive function) was 13, indicating that the resident's cognition was intact. A review of the resident's comprehensive plan of care, which was initiated on February 13, 2020, revealed that an incontinence management program was devised for the resident. This care plan was last reviewed/revised on February 2, 2022. The plan included keeping the resident clean, dry, odor free and preventing skin breakdown. To achieve this, the resident was to use absorbent incontinency products to protect the resident's clothing and maintain resident dignity. An established routine was to be followed, which included changing the resident upon awakening, before and after meals/activities and every two hours while he was awake. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident A2's consultation with a cardiac electrophysiology physician dated April 26, 2022, the assessment/plan for the resident was to continue with previous established plans. This physician documented, however, that he questioned the cleanliness/care of the facility as the resident was sent for his appointment, likely without the use of an appropriate brief, as the resident had been incontinent. He further stated that his staff had observed the resident's requests to use the bathroom ignored by the facility staff member who had accompanied him. When the EKG technician had taken the resident back to the examination, she had witnessed the resident being incontinent, with a puddle of urine beneath the wheelchair. The physician documented that he had also witnessed this resident's incontinence and the aide's failure to toilet the resident. A review of a physician note from the resident's visit dated April 26, 2022 revealed that the physician noted {Resident A2} resides in the facility, was transferred to the hospital emergency room secondary to acute mental status change and lethargy. The noted assessment/plan stated; would question cleanliness of the nursing home given that he likely did not have a diaper on and was allowed to soil himself despite his request to go to the bathroom. His aide ignored his request prior to my seeing him. Testimony given by EKG tech, who roomed the patient. Upon entering the room, I noted a puddle of urine underneath the wheelchair. A statement from the facility's Nusing Home Administrator (undated) regarding this incident revealed that Employee 9 left the facility after the incident of April 26, 2022, and has not returned. The NHA's statement stated that the facility attempted to contact Employee 9 on April 28, 2022, at 4 PM, April 29, 2022, at 11 AM and 1:45 PM, April 30, 2022 at 12:15 PM and May 1, 2022 at 2 PM without success. As a result, the facility had not obtained a statement from Employee 9 regarding the incident. A review of a facility human resources file revealed that Employee 9 received her temporary nurse aide certificate on August 8, 2021 and was hired at the facility on December 13, 2021. Facility documentation revealed that Employee 9 received facility abuse training on December 13, 2021. Interview with the representative from the Lackawanna County Area Agency of Aging, responsible for investigation of this incident, was conducted via telephone on May 2, 2022, at 9:45 a.m. She confirmed that her office had received the report of need for neglect of this resident. The AAA rep confirmed that she went to the long term care facility to interview the resident on April 28, 2022. She stated that the resident confirmed that he had asked Employee 9, the facility staff member accompanying him to the appointment, to take him to the bathroom on numerous occasions while at the appointment. According to the resident, Employee 9 either ignored the resident's request or told him to wait. The resident stated that he was not wearing a brief while out at the appointment and he became incontinent of urine while waiting to see the physician. He stated that Employee 9 never took him to the bathroom or attempted to change him after he was incontinent. The resident confirmed that he remained wet from incontinency during his appointment and while transported back to the facility in the van. The resident confirmed that he received no attention for his incontinency until he returned to the nursing home. This AAA representative stated she gave the resident a mini mental examination and found the resident's cognition to be intact and his statement factual and consistent. She further stated that she confirmed with facility administrative staff, that they had determined the resident was capable of exercising his rights and making his needs known. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility had planned interventions related to this resident's continency needs, including the use of incontinence products and the resident's assessed needs of requiring the extensive assistance of two staff members for transfer and toileting, but the facility and facility staff, failed to provide the care and attention this resident required and a the resident experienced an episode of incontinency in public, at the physician's office. The facility staff member ignored the resident's requests for assistance for toileting, and did not provide the resident with any incontinency care after the episode at the physician's office. During an interview with the nursing home administrator on May 2, 2022, at approximately 10 AM, the NHA was unable to demonstrate that Resident A2 had received the necessary services to prevent personal discomfort, distress and public embarrassment. 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c)(d) Resident Rights 28 Pa. Code 211.12(a)(c)(d)(3)(5) Nursing Services

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records, select facility and investigation reports and staff interviews it was determined that the facility failed to ensure that one of 29 residents sampled was not manually restrained and failed to assure that the resident was free from physical abuse. (Resident A 3) Findings include: Review of a facility policy for Abuse prevention, dated as reviewed by the facility January 2022, revealed that it is the policy of this facility to provide a safe resident/employee environment by maintaining an abuse free atmosphere. A review of the clinical record of Resident A3 revealed admission to the facility on [DATE], with diagnoses to include drug induced polyneuropathy (Drug-induced polyneuropathy is damage of multiple peripheral nerves, in a relatively symmetric fashion, due to various drugs) and schizoaffective disorder (Schizoaffective disorder is a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania). A review of a a quarterly Minimum Data Set assessment ((Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 5, 2022, revealed Resident A3 was cognitively intact and required maximum staff assistance with activities of daily living. A review of the resident's care plan for the problem that the resident has the potential to exhibit distressed mood & behavioral symptoms dated June 23, 2021, noted the planned interventions of approaching the resident in a calm and unhurried manner, explain all routines & procedures to Resident A3 to decrease paranoia and reattempt and reapproach as needed. A review of a facility investigation report and a Pennsylvania Department of Health PB-22 report form for investigation of alleged abuse, neglect or misappropriation of property dated April 24, 2022, at 5 AM, revealed that on April 26, 2022 at 11:30 AM, the social worker from Resident A3's managed care insurance company went to see the facility social services director during a visit to the facility. It was noted that Resident A3 had informed the managed care social services worker that during the resident's care, two nights ago, around 5 AM, a large blond female nurse aide slapped her and held her wrist while the nurse aide was trying to cut her nails. During the investigation the facility identified the nurse aide involved in the incident. Employee 6 (nurse aide) was suspended pending the outcome of the investigation. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of employee witness statement from dated April 26, 2022 (no time indicated) revealed that Employee 8, a nurse aide employed by a staffing agency, stated that on Sunday morning (April 24, 2022), while changing Resident A3, I had another aide (Employee 6), because one day {Resident A3} put her hands on my neck while 2 EMT's (emergency medical technicians) were in the room. While changing the resident, she had scratched the other aides arm, while she was rolled on one side. I realized her pad was wet, so I ran out in the hall to grab a new one. When I was coming back into the room, I saw the nurse aide (Employee 6, with her hand on both {Resident A3}'s wrists and had them criss crossed and pinned down on her {the resident's} chest. When finished changing {Resident A3}, Employee 6 clipped her {the resident's} nails. During the nail cutting, {Resident A3} was not pulling her arm back or fighting against it. During an interview April 28, 2022 at approximately 10:30 AM, Resident A3 stated that that aide hurt me. She stated that the aide involved in the above incident (identified as Employee 6) hurt her. At the time of the interview, Resident A3 showed this surveyor a healing scratch on her right wrist, approximately 1 inch long, which she says was caused by Employee 6 while the aide was holding her down to cut her nails. A review of a witness statement dated April 26, 2022 at 1 PM revealed that the accused employee, Employee 6, the aide assigned to Resident A3's care at the time of the incident, stated we are getting ready for last rounds. Employee 8 asked for help with {Resident A3} because in the past {Resident A3} had scratched her. I said OK, I will help you. Normally I do not have a problem with {Resident A3}, I usually get along with her. I went in her room and {Resident A3} was screaming so bad I could not understand what she was saying. I asked {Resident A3} what was wrong and she flipped out. She started scratching, punching and cursing at me. I was there with Employee 8. {Resident A3} was the same way the morning before, acting out around the same time. I told {Resident A3} that when she scratched me, I had to cut her nails. This is what we have been told since I started working here. If someone has long nails, you cut them. I have scratch marks on my arms and hands from {Resident A3}. We never go into her room without someone else because of her behaviors and her accusations. Employee 6 stated that the other nurse aide left the room to get nail clippers. Employee 6 stated that at that time she moved away from Resident A3 because the resident was swinging and spitting. Employee 6 verified that she held the resident's hand while cutting her nails. A review of staff inservicing documents revealed that both Employee 6 and Employee 8 had been inserviced on the facility abuse prevention policy on March 7, 2022. During an interview April 28, 2022 at approximately 1 PM, the Nursing Home Administrator (NHA) confirmed that abuse is not tolerated in the facility and confirmed the account of the incident of manual restraint noted above, which caused the resident minor injury. Refer F842 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing Services 28 Pa. Code 201.29(a)(j) Resident rights

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41520 Based on a review of clinical records and the Resident Assessment Instrument and staff interviews, it was determined the facility failed to ensure the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of 29 sampled (Residents B1). Findings include: According to the RAI User's Manual, Section O 0250 Influenza Vaccine, once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins. A review of the facility policy provided at the time of the survey ending April 28, 2022, revealed the that the influenza season was from October 1st through March 31st. Review of Resident B1 quarterly MDS assessment dated [DATE], Section O 0250 letter A. Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? An entry of 0 indicating No . Section O 0250 letter C. states, If the influenza vaccine was not received, state reason, had an entry of 5 indicating the vaccine was not offered . Review of Resident B1's clinical record revealed a progress note dated November 25, 2021 at 9:24 AM indicating the resident received the influenza vaccine in her left deltoid. Review of Resident B1's immunization record revealed that the resident received the influenza vaccine on November 25, 2021. Interview with the Nursing Home Administrator on April 28, 2022, at 2:00 PM confirmed that Resident B1 did receive the influenza vaccine during the facility's influenza season and the quarterly MDS assessment dated [DATE], was inaccurate. 28 Pa. Code 211.5(g)(h) Clinical records 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41520 Based on observations, a review of clinical records and select facility policy and staff interviews it was determined that the facility failed to provide a resident dependent on staff for assistance with activities of daily living, the services necessary to maintain good personal hygiene and grooming, resulting in palm puncture wound from long imbedded fingernails and the subsequent development of an infection, which required hospitalization for treatment of one resident out of 29 reviewed (Resident B1). Findings include: A review of facility policy entitled: Bath/Shower indicates it is the facilities policy to provide residents with a minimum of ONE bath/shower a week or as indicated by condition and Plan or Care. To clean and refresh the resident. Step 16 indicates, to clean clip and file fingernails as needed. Step 18. Indicates, complete bath/shower skin assessment at this time. A review of the facility procedure entitled, Care of Fingernails/Toenails the purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections. In preparation staff are to review the resident's care plan to assess for any special needs of the resident. The procedure is outlined as follows: Place the equipment on the bedside stand or overbed table. Arrange supplies they can be easily reached Wash and dry your hands thoroughly Fill wash basin one-half full of warm soapy water Allow the first hand to soak in the warm soapy water for approximately 5 minutes. Encourage the resident to exercise his or her fingers Rinse hand that has been in the soapy water with clear, warm water Dry the hand with a towel Gently, remove the dirt from around and under each nail with an orange stick Trim fingernails in an oval shape Smooth the nails with a nail file or emery board A review of the clinical record revealed that Resident B1 was admitted to the facility on [DATE], with diagnoses, which included unspecified dementia with behavioral disturbances, anxiety disorder and depressive disorder. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	A review of Resident B1's quarterly MDS Assessment (Minimum Data Set - a federally mandated standardized assessment process completed periodically to plan resident care) dated February 10, 2022, revealed that the resident was totally dependent on staff assistance for bathing and required assistance of two staff members for personal hygiene, which can include combing hair, shaving, brushing teeth, applying makeup, washing/drying face and hands. At the time of this assessment the resident was identified without impairment in her range of motion. The resident was assessed as severely cognitively impaired. A review of Resident B1's current plan of care, initially dated February 21, 2018, revealed that Resident B1 was identified as having the potential to exhibit distressed mood/behavioral symptoms related to diagnosis of anxiety and depression, mood lability as evidenced by flat affect, anxiety AEB (as evidenced by) repetitive questions, anxiety as evidenced by restlessness fidgeting, aggression/combative with care yelling at peers, and biting. The planned interventions were to approach in a clam and unhurried manner to decrease potential anxiety, encourage and allow time for resident to express her feelings, encourage involvement in care and treatment decisions, explain all routines and procedures to attempt to decrease potential aggression/combative with care, if resident yelling and screaming or attempting to bite staff and its during giving care re approach and/or get someone to give care. Observe for any changes in mood/behavior (i.e.: flat affect, Anxiety AEB repetitive questions, anxiety AEB restlessness/fidgeting, yelling and screaming, attempting to bit staff, aggression/combative with care, yelling at peers, biting staff etc.) and overall functioning and document, reattempt and reapproach prn (as needed), and validate feelings as expressed. Additional review of Resident B1's current plan of care initiated on April 2, 2019, revealed that Resident B1 can exhibit noncompliant behaviors as evidenced by refusing showers with a goal of the resident will accept prescribed treatment or recommendations for care through the next review with the following interventions planned: Resident will be offered appropriate alternatives when possible, Resident will be informed of risk versus benefits of noncompliance, encourage resident to verbalize, if able reason for non-compliant behavior, Notify MD of recurrent non-compliance and possible alternatives to treatments, medications, and recommendations etc, and notify social worker of non-compliant behavior. The resident was identified as at risk for skin tears with the following interventions planned: keep fingernails trimmed and filed smooth. A physician order dated December 28, 2021, indicated that Resident B1 is to have a skin assessment conducted by a licensed nurse every Tuesday and Fridays with her shower. A review of Resident B1's clinical record indicated that from March 1, 2022 to the time of the survey ending April 28, 2022, there was one entry dated March 27, 2022, at 6:31 AM indicating, CNA notified nurse resident attempting to bite staff during AM care, nurse in to assess, resident denies c/o (complaints of) pain or discomforts, resident not incontinent at this times, offered repositioning but declines, requesting a drink, drink given. RN supervisor aware of same. A review of the resident's April 2022 Treatment Administration Record revealed a skin assessment was completed by the licensed nurse on April 1, 2022, April 5, 2022, April 8, 2022, April 12, 2022, April 15, 2022, April 19, 2022, and April 22, 2022. There were no findings or abnormalities noted as a result of these skin assessments. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	A review of the April 2022 Documentation Survey Report completed by nurse aides revealed there was no documented evidence that Resident B1 received a shower on April 1, 2022 or April 5, 2022 or April 19, 2022. There was no indication in the clinical record the resident was exhibiting non-compliant behaviors and or refused to be showered. Further review of the April 2022 Documentation Survey Report revealed documentation indicating that the resident was showered on April 8, 2022, April 12, 2022, and April 15, 2022 and April 22, 2022. Review of the April 19, 2022, skin monitoring form completed by a nurse aide revealed that Resident B1's fingernails were cleaned and clipped and the resident did not refuse her shower. Review of the April 22, 2022, skin monitoring form completed by a nurse aide revealed Resident B1 was provided a shower, but the form noted that the resident's fingernails were not cleaned or clipped if needed. Two days after the resident's last documented shower, and five days after the resident's last documented nail clipping, a review of a nursing progress note dated April 24, 2022 at 10:13 PM indicated a nurse aide called the nursing supervisor. The entry noted resident right hand very foul smelling. Hand clenched tight. Attempted to open hand and resident screams. Observed long fingernail growing, digging thru palmar part of hand. A review of a nursing progress note dated April 24, 2022 at 11:19 PM indicated the resident's right hand is contracted. Foul smelling odor. Attempted to pry open fingers, resident yelling c/o pain and CNA observed nail growing in palm of hand. A review of a progress note dated April 25, 2022 at 3:43 PM indicated the resident was admitted to an acute care hospital with a right hand palmar wound. A review of the hospital emergency room documentation dated April 25, 2022 at 3:51 AM revealed that the physical exam, under the physician findings revealed there was a distinct necrotic road kill odor from the resident's right hand. The physical exam of the skin revealed, on the right hand there are 2 distinct puncture wounds where the 2nd and 3rd digits of the right hand have very long nails and have forced a necrotic pressure ulceration type puncture wound and are imbedded. There is erythema swelling and purulent discharge of these wounds of the right palm. The physical exam of the neurological system revealed, patient's right hand is contracted and balled into a fist. IV antibiotic Zosyn (dosage not indicated in documentation) was initiated for the resident's treatment in the emergency department. According to the hospital documentation, the final diagnostic impression based on the emergency room visit was: 1. Acute necrotic puncture wounds to right hand from autodigital trauma, 2. Right hand cellulitis, 3. Severe dementia. {Resident B1} was admitted for inpatient services on April 25, 2022 at 6:48 AM. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Review of a hospital consult note dated April 25, 2022 for Orthopaedic Trauma identified the resident's right upper extremity as follows: 2 deep Open wounds when fingers opened up. Look to be down into the tendons and musculature, but no overt bone seen. When not clenched, 2nd and 3rd digits fill the wounds to about the nail bed. Resident B1 was discharged from the acute care hospital on April 27, 2022, with the following recommendations: Amoxicillin- Clavulanate (Augmentin) 500-125 Milligrams provided 1 tablet in the morning and 1 tablet at bedtime prescribed for 10 days to be completed on May 5, 2022, follow up with a hand surgeon, daily dressing changes to right hand; apply 4 x 4s in between fingers and protect palmar aspect of the hand, occupational therapy recommends washcloth roll in hand as patient tolerates secondary to wound, do not recommend pre-fab resting hand splint at this time to avoid increasing pressure to wound. Interview with the Director of Nursing on April 28, 2022 at approximately 10:00 AM revealed that the resident's nails, which punctured the palmar aspect of this resident's hand, were approximately 1 inch in length. The DON was unable to explain this finding as the nurse aide documentation noted that the resident's fingernails were clipped on April 19, 2022. The DON then confirmed that it appeared, based on the hospital findings, that the nurse aide did not clip the resident's nails as noted on that date. Observation of the wounds on the palmar aspect of the right hand at the time of the survey ending April 28, 2022 at 1:30 PM, in the presence of the wound care specialist and occupational therapy revealed that the resident was resistive to care, pulling hand away from the health care providers, and was attempting to bite them. Multiple staff members tried to calm the resident, while opening her hand to allow assessment of the area. The two puncture areas were visually observed briefly to allow measurement by the wound care specialist and the areas were observed to be closed. Review of wound care specialist documentation dated April 28, 2022, revealed that the wound specialist had documented the resident has one wound to the right hand identified as a full thickness (damage extends below the epidermis and dermis [all layers of the skin] into the subcutaneous tissue or beyond [into muscle, bone, tendons, etc.] healing, self-inflicted nail trauma measuring 2 centimeters x 0.5 cm x 0.1 cm with light serous exudate noted, when there were two distinct areas visualized on the [NAME] surface of the right hand. The wound specialist dressing treatment plan recommendation was for the primary dressing: Hydrogel apply once daily for 30 days and secondary dressing: gauze island with boarder to be applied once daily for 30 days. Review of the Occupational Therapy consult dated April 28, 2022 revealed that the resident has a right hand contracture identified as patient with contractures to R (Right) hand digits (fingers) II-V(II-index, III-middle, IV-ring, V-pinky) at MCP (metacarpophalangeal- or knuckle, is where the finger bones meet the hand bones) joints with limitation to PIP (proximal inter-phalangeal- is the middle joint of each of your fingers) joints, patient with previous limitations of ROM in addition to increased behaviors and tendencies to fist R hand present with functional use of hand limitations including ADL dysfunction. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	There was no indication that the facility had timely identified the resident's developing contracture and limitations in range of motion, which the OT noted as previously developed. According to the resident's MDS assessment of February 10, 2022, the resident had no contractures or limitation in range of motion. There was no documented evidence that the facility had timely identified and addressed this decline from the time of the quarterly MDS assessment through the development of the resident's palmar injury identified on April 25, 2022. The facility failed to demonstrate the consistent implementation of the resident's care plan to promote compliance with care and activities of daily living and was unable to demonstrate that the resident had consistently been provided with the care and services necessary to maintain good personal hygiene and grooming. As a result of the failure to consistently provide necessary ADL assistance for grooming and personal hygiene, the resident developed an infected wound on her palm as the result of long fingernails and contracted hand. The resident required hospitalization for IV antibiotic therapy and treatment of the wound. Interview with the Nursing Home Administrator on April 28, 2022 at approximately 2:30 p.m. confirmed that the facility failed to consistently provide necessary care and services with activities of daily living for a dependent resident and promptly identify the resident's hand injury, resulting in an infected wound requiring hospitalization . 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.12(a)(c)(d)(5) Nursing services.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review and resident and staff interviews, it was determined that the facility failed to consistently provide an ongoing program of activities as planned to meet the needs, interests and functional abilities of one of 29 sampled residents (Resident A4) Findings include: Clinical record review revealed that Resident A4 was admitted to the facility on [DATE], with diagnosis to include metabolic encephalopathy (A medical term used to describe a disease that affects brain structure or function. It causes altered mental state and confusion). A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated February 15, 2022, indicated that the resident has a BIMS [Brief Interview of Mental Status-a tool to assess cognitive function] score of 7 (a score of 0-7 indicates severe cognitive impairment). The MDS section F, activity preferences included, reading magazines, music, animals, group activities participation, favorite activity participation going outside and attending religious activities. A review of an activity care plan dated February 16, 2022, revealed planned interventions to include, offer, invite and assist Resident A4 to all one to one interventions/activities especially those of her assessed interest such as music & entertainment, religious programs, pet visits, social events, outdoors in nice weather, and discussions. A review of Resident A4's monthly activity participation log for February 2022 revealed : February 16, 2022- Initial assessment complete, please read info on computer February 22, 2022- 1 to 1 visit, socialized about current events on television February 28, 2022- discussed her family and television shows Resident A4's monthly activity participation log for March 2022 revealed: March 2, 2022- 1 to 1 visit-discussed television, religion and current events March 3, 2022- current events, chit-chat March 10, 2022- discussed her health March 15, 2022- 1 to 1 visit, discussed current events and her health (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	March 22, 2022- 1 to 1 visit, discussed TV shows and her family Resident A4's April 2022 activity participation log revealed: April 7, 2022 - afternoon greetings, tray pass and chit-chat April 12, 2022- Easter card visit April 15, 2022- Easter reminiscence April 17, 2022- Family visit April 22, 2022- Family visit Review of the facility's Activity Calendar for February 2022, March 2022 and April 2022 indicated that there were daily activities provided to residents to include exercise sessions, food related activities, group activities to include music and outside entertainment. There was no documented evidence provided at the time of the survey ending April 28, 2022, that Resident A4 was offered or encouraged/assisted to attend any of the scheduled activities included on the February 2022, March 2022 or April 2022 activity calendars. Interview with The Activity Director on April 28, 2022, at 12:30 PM confirmed that there was no documented evidence that the facility consistently provided Resident A4 the preferred activities in her activity care plan. 28 Pa. Code 201.29(j) Resident rights

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records and select resident incident/accident reports and staff interview, it was determined that the facility failed to address a newly admitted resident's known safety risk factors from the time of the resident's admission and promptly implement necessary safety measures including adequate supervision to prevent a fall and significant injuries, a serious head injury and facial fractures, sustained by one resident out of 29 sampled (Resident CR3) Findings include: A review of the clinical record revealed that Resident CR3 was admitted to the facility on [DATE], with diagnoses that included non-traumatic subdural hemorrhage (bleeding between the brain and its outermost covering), hemiplegia and hemiparesis (paralysis on one side of the body) following cerebral infarction (a disruption of blood flow to the brain) of the non-dominate side, falls, muscle weakness, unsteadiness on feet, lack of coordination, and abnormal posture. A review of hospital paperwork received by the facility upon the resident's admission to the long term care facility revealed that the resident was assessed at the hospital by Physical Therapy (PT) and Occupational Therapy (OT) prior to admission to the long term care facility. According to these assessments by specialized rehab completed prior to the resident's admission to the long term care facility, on April 25, 2022, Physical Therapy evaluated the resident and documented the resident had poor sitting balance, was on precaution for falls and safety, and used a bed alarm. It was noted that the resident would require PT services at the long term care facility due to poor safety, mobility, balance, and endurance. On April 25, 2022, Occupational Therapy evaluated the resident and documented the resident had poor sitting balance, used a bed alarm, was on precaution for falls and safety, has decreased awareness, and has poor sitting tolerance endurance. It was noted that the resident would also require OT services at the long term care facility due to poor safety, mobility, balance, and endurance. A review of a facility admission fall risk assessment dated [DATE], revealed that the resident was identified at high risk for falls upon admission to the long term care nursing facility. A review of a nursing progress note dated April 26, 2022, at 11:58 AM revealed that the resident was found lying face down on the floor in front of her wheelchair in front of the nurse's station. The resident was noted to have blood coming from her nose and was transported to the hospital. A review of a facility incident report dated April 26, 2022, revealed that the resident was found lying face down on the floor with blood coming from her nose and a 2 cm (centimeter) laceration to the right side of her nose. The incident report noted that the resident was at risk for falls, identified prior to the fall on April 26, 2022, but the only planned intervention in place were bed bolsters. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	This newly admitted resident's fall had occurred while the resident was out of bed in the wheelchair, unsupervised by staff. A review of the resident's care plan, for at risk for falls, revealed that the initial baseline care plan was not initiated until April 26, 2022, after the resident had fallen. Planned individualized interventions were not in place at the time of admission to addresss the newly admitted resident's need for staff supervision to prevent the resident's falls. The facility was aware of the resident's fall risk at the time of the resident's admission, but failed to develop and implement necessary interventions from the time of admission to maintain this resident's safety and prevent falls. A review of a hospital report dated April 26, 2022, revealed that the resident was seen at the hospital for an evaluation for a fall at 10:07 AM. According to this hospital report, the EMS (emergency medical services - present in the facility for another reason) staff witnessed the resident's fall. The EMS staff that the resident fell from her wheelchair. The report documented that the resident had a new increased subdural hematoma (bleeding on the brain) along the left cerebral cortex (left side of the brain) and non-displaced nasal bone fractures (broken bones in the nose) with tissue swelling. A telephone interview on April 28, 2022, at 11:48 AM was conducted with the EMS staff that witnessed Resident CR3's fall. The EMS staff member stated that she was there on a call for another resident when she noticed Resident CR3 sitting in the wheelchair in front of the nursing station. The EMS employee stated that the resident was not properly positioned in the wheelchair and was bent over, leaning forward, almost in half. Further the EMS staff stated she wasn't sure if the resident tried to get up or just fell forward, but the resident fell head first out of the wheelchair and landed directly on her face on the floor. The EMS employee stated that she yelled for help because there was no staff present in the area. The resident was identified at risk for falls upon admission to the facility. The facility was aware, based on the assessments by PT & OT conducted immediately prior to the resident's admission to the long term care facility, that the resident had poor sitting balance and poor sitting tolerance endurance as noted in their assessments of April 25, 2022. The facility failed to develop and implement individualized safety measures, including necessary staff supervision, based on the newly admitted resident's known risk factors, from the time of the resident's admission to the facility to prevent the resident's fall from the wheelchair on April 26, 2022. An interview with the Nursing Home Administrator on April 28, 2022, at approximately 2:30 PM confirmed that the facility failed to provide effective safety interventions, including necessary staff supervision of a resident with known risk factors, including balance poor sitting balance and was a high fall risk upon admission to prevent Resident CR3 from falling and sustaining signifcant injuries. 28 Pa. Code 211.11(d) Resident care plan 28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records and staff interview, it was determined that the facility failed to consistently implement individualized approaches planned to restore normal bladder function to the extent possible for two out of 29 residents sampled (Resident D7 and D8). Findings include: A review of Resident D7's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included spinal stenosis (pressure on the spinal cord that can cause pain, numbness, or muscle weakness) and overactive bladder. An Admission Minimum Data Set Assessment (MDS -a federally mandated standardized assessment completed at specific intervals to define resident care needs) dated April 8, 2022, indicated that the resident required extensive assistance of two staff for toileting and was frequently incontinent of bowel and bladder. A review of the resident's current plan of care initially dated April 8, 2022, revealed an approach to provide a scheduled toileting due to the resident being frequently incontinent of bowel and bladder. The planned intervention directed that the resident be toileted at 2:00 AM, 8:00 AM, 11:00 AM, 2:00 PM, 4:00 PM, 7:00 PM, 10:00 PM, and when the resident asks. A review of nurse aide tasks completed for Resident D7 during the month of April 2022, indicated that the resident's toileting program was not completed on April 26, 2022, at 8:00 AM, 11:00 AM, and 2:00 PM as planned. There was no documented evidence of the resident's bowel and bladder activity/continence on April 26, 2022, for the 7:00 AM to 3:00 PM shift. The facility failed to consistent implement the resident's scheduled toileting plan in an attempt to improve the resident's bowel and bladder continence. A review of Resident D8's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that unspecified dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning). An Admission Minimum Data Set assessment dated [DATE], indicated that the resident required extensive assistance of two staff for toileting and was frequently incontinent of bowel and bladder. A review of the resident's current plan of care revealed a care plan initially dated April 11, 2022, for incontinence management program. A current intervention was planned for the resident to be toileted at 1:30 AM, 7:30 AM, 6:30 PM, and 9:30 PM A review of nurse aide tasks completed for Resident D8 during the month of April 2022, revealed that the resident's toileting plan was not completed on April 26, 2022, at 7:30 AM. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on April 28, 2022, at approximately 2:30 PM confirmed that the facility failed to consistently implement the planned individualized approaches to restore normal bladder function to the extent possible for these residents. 28 Pa. Code 211.12 (a)(d)(1)(5) Nursing services 28 Pa. Code 211.11 (c)(d) Resident care plan

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41520 Based on review of clinical records, observations, and staff interviews it was determined that the facility failed to ensure the ready availability of necessary emergency supplies for two residents out of two sampled receiving hemodialysis (Resident B2 and B3). Findings include: A review of the clinical record revealed that Resident B2 was readmitted to the facility on [DATE], with a diagnoses to include renal insufficiency and receives hemodialysis. The resident has a left tunneled jugular double lumen catheter (tunneled catheter usually enters the skin below the collar bone [clavicle] and travels under the skin to enter the jugular vein, with its tip in the very large vein [the vena cava]) for dialysis access on Monday and Friday. According to the resident's current care plan, an emergency bleed kit is to be available at the bedside and wheelchair including clamp and gauze. If bleeding at site occurs apply pressure/clamp, contact MD and prep for transport. Observation of the resident on April 28, 2022 at 9:25 AM failed to reveal the bleed kit at the bedside or to his wheelchair as care planned. Interview with Employee 1, Licensed Practical Nurse Unit Manager, on April 28, 2022 at 9:30 AM confirmed that the kit was not readily available at the resident's bedside and wheelchair. Employee 1 began going through Resident B3's bedside table and found a kit, but it lacked clamps. Employee 1 confirmed the kit was incomplete and lacked all items. Employee 1 also verified that there was no emergency kit on the resident's wheelchair. A review of the clinical record revealed that Resident B3 was admitted to the facility on [DATE], with a diagnosis to include End Stage Renal Disease and receives hemodialysis. The resident has an AV fistula (An arteriovenous [AV] fistula is a connection, made by a vascular surgeon, of an artery to a vein. Provides good blood flow for dialysis) for dialysis access on Mondays, Wednesday and Friday. According to the resident's current care plan, soft clamps were to be present at bedside/wheelchair for external port catheter. If bleeding is noted, staff are to clamp and send to the emergency room . An observation and interview with the resident on April 28, 2022, at 9:32 AM revealed there was no emergency equipment located in the resident's room. A wheelchair was not observed in the resident's room. This absence of emergency supplies was confirmed by Employee 1, Licensed Practical Nurse Unit Manager on April 28, 2022 at 9:32 AM. Employee 1 also confirmed that the resident's current care plan was inaccurate as the resident has an AV fistula and not and external port catheter. 28 Pa. Code 211.12 (a)(d)(1)(3)(5) Nursing services. 28 Pa. Code 211.11(d) Resident care plan

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review and staff interview, it was determined that the facility failed to ensure timely physician visits for 7 of 29 sampled residents (Residents A1, A 3, A5, A6, A7, A12 and A8). Findings included: A review of the clinical record revealed that Resident A1 was admitted to the facility on [DATE]. A review of physician's progress notes revealed that the resident was seen by the physician on August 8, 2021, and the CRNP (certified registered nurse practioner) on December 28, 2021. On February 11, 2022, Resident A1 fell from her wheelchair and sustained a left hip fracture. There was no documented evidence at the time of the survey ending April 28, 2022, that Resident A1 was seen by her attending physician or Physician extender since the last visit of December 28, 2021. A review of the clinical record revealed that Resident A3 was admitted to the facility on [DATE]. A review of physician's progress notes indicated that the resident was seen by the physician on October 29, 2021. There was no documented evidence at the time of the survey ending April 28, 2022, that the resident was seen by the physician since the visit October 29, 2021. A review of the clinical record revealed that Resident A5 was admitted to the facility on [DATE]. A review of physician's progress notes indicated that the resident was seen by the physician on July 27, 2021, and the CRNP (certified registered nurse practioner) on February 8, 2022. There was no documented evidence that the resident was seen by the physician or physician extender since February 8, 2022. A review of the clinical record revealed that Resident A6 was admitted to the facility on [DATE]. A review of physician's progress notes indicated that the resident was seen by the physician on August 21, 2021. There was no documented evidence at the time of the survey ending April 28, 2022, that the resident had been seen by the physician since August 21, 2021. A review of the clinical record revealed that Resident A7 was admitted to the facility on [DATE]. A review of physician's progress notes indicated that the resident was seen by the physician on August 21, 2021 and not seen again until the CRNP (certified registered nurse practioner) visit on March 15, 2022. A review of the clinical record revealed that Resident A12 was admitted to the facility on [DATE]. A review of physician's progress notes indicated that the resident was seen by the physician on August 21, 2021. There was no documented evidence of a physician visit since that date as of the time of the survey ending April 28, 2022. A review of the clinical record revealed that Resident A8 was admitted to the facility on [DATE]. A review of physician's progress notes indicated that the resident was seen by the physician on July 27, 2021, and not seen again until the CRNP (certified registered nurse practioner) visit on March 15, 2022. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the NHA (nursing home administrator) on April 28, 2022 at 1:00 PM confirmed that the three attending physicians were not making regular visits at the frequency required by the regulation. 28 Pa Code 211.2 (a) Physicians services 28 Pa. Code 201.18(b)(1)(3)(e)(3) Management

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41581 Based on observation, review of select facility policy and staff interview, it was determined that the facility failed to identify use by/discard dates for multidose insulin for two of 29 residents sampled (Residents D1 and D4) Findings include: A review of the facility's policy entitled Insulin Administration last reviewed December 7, 2021, revealed that staff are to check the expiration date on the insulin if drawing from an opened multi-dose vial/insulin pen. When opening a new vial/pen, record expiration date and time on the vial/pen. An observation of the C2 nursing unit medication cart on April 27, 2022, at approximately 10:45 AM revealed the following: Resident D1's Novolog Solution Vial 100 units/ml (Insulin) and Lantus Solution Vial 100 units/ml (Insulin) were opened but not dated Resident D4's Novolog Solution Vial 100 units/ml (Insulin) was opened but not dated. These insulin vials observed were not dated when opened and put into use or when the vials were to expire. An interview with Employee 4, LPN (license practical nurse), on April 27, 2022, at approximately 10:45 AM revealed that Employee 4 stated that all insulins should be dated when opened and disposed of 28 days after opening. Employee 4 confirmed that the observed residents' insulins were not dated as per the policy. 28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services 28 Pa Code 211.9 (k)(1)(2) Pharmacy services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate clinical records for one of 29 sampled residents (Resident A 3). Findings include: Clinical record review revealed that Resident A3 was admitted to the facility on [DATE], with diagnoses of drug induced polyneuropathy (Drug-induced polyneuropathy is damage of multiple peripheral nerves, in a relatively symmetric fashion, due to various drugs) and schizoaffective disorder (Schizoaffective disorder is a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania.) A review of a a quarterly Minimum Data Set assessment ((Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 5, 2022, revealed that Resident A3 was cognitively intact and required maximum assistance of staff for activities of daily living. A review of a facility investigation report and a Pennsylvania Department of Health PB-22 report form for investigation of alleged abuse, neglect or misappropriation of property dated April 24, 2022, at 5 AM, revealed that on April 26, 2022, at 11:30 AM, the social worker from Resident A3's managed care insurance company went to see the facility's social services director. Resident A3 had informed the managed care social services worker that during there resident's care two nights ago, around 5 AM, a large blond female nurses aide slapped her and held her wrist while trying to cut her nails. During an interview April 27, 2022 at approximately 10:30 AM, the D unit, LPN unit manager stated that Resident A3 has a managed care insurance plan. This plan includes the services of professional staff, including social workers, providing care and services to the resident in the facility. Resident A3 receives these services several times a month from the staff of the managed care insurance company. The unit manager explained that the D unit staff do not know when these medical professionals are scheduled to be in the facility to provide care to the resident. She further stated that these medical professionals do not document in the resident's electronic health record or paper medical record maintained by the facility. She stated that if there are any issues of concern these medical professionals provide the facility staff a verbal report at the time of their visit. The Unit Manager stated that at the time of the social services visit, April 26, 2022, the managed care social worker reported to the unit manager that Resident A4 had informed her that 2 days prior, on the 11 PM to 7 AM shift a nurse aide slapped her and held her down. During an interview April 28, 2022 at approximately 1 PM, the Director of Nursing stated that the facility currently has multiple residents with managed care insurance plans. She stated that the insurance providers refuse to provide documentation of their staff's visits and any care provided to the residents to the facility to incorporate into the resident's medical record. The DON confirmed that none of the care or services provided to the residents by the medical professionals from the managed care insurance company is contained or maintained in the residents medical records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was unable to demonstrate that the medical records of these residents contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatments and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions and that the clinical record included all progress notes and documentation from nurses and other licensed professionals progress notes providing care and services to the resident. 28 Pa Code 211.5 (f)(g)(h) Clinical records 28 Pa Code 211.12 (a)(c)(d)(1)93)(5) Nursing Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41581 Based on observations, a review of clinical records and select facility policies, and staff interview it was determined that the facility failed to consistently adhere to infection control techniques while caring for residents on transmission based precautions including for COVID-19 and failed to implement procedures to deter the spread of influenza in the facility as evidenced by 10 of 29 residents sampled. (Resident D1, C2, CR4, C3, D2, D3, D5, C4, C6, D6) Findings included: Review of the facility's policy entitled Policy for Covid-19 Zones last reviewed by the facility on December 7, 2021, indicated the facility strives to keep residents safe and healthy. Due to recent health concerns the facility will be utilizing color zones to identify areas of the facility that need to use adequate PPE in order to enter. The yellow area will be occupied by residents who have had or may have had an exposure to a person with known covid-19. Full PPE is required in this area. Upon entering the B2 unit of the facility on April 27, 2022, at 8:45 AM, a sign was observed posted on the wall which identified the area as a yellow zone. The residents in the zone are not presently positive for Covid-19, however, they may have been exposed to the virus and are in a quarantine area of the facility. The posting indicated that staff are required to wear full PPE (N95, masks, goggles, gloves and gown) to enter the residents' rooms and to provide patient care. On April 27, 2022, at approximately 8:30 AM, Employee 3 (Physical Therapists) was observed exiting resident room B258 (a yellow quarantine room). Employee 3 was wearing an N95 mask, but he was not wearing any other required PPE equipment according to facility policy to mitigate the spread of COVID-19. Interview with the Nursing Home Administrator (NHA) on April 27, 2022, at 9:19 AM, the NHA confirmed that all staff are required to wear full PPE in quarantine rooms (yellow zone). Interview with Employee 3 on April 27, 2022, following the observation revealed that he stated that staff are required to wear full PPE in the quarantine rooms and he confirmed that he did not, but should have full PPE on when in the resident's quarantine room. A review of Resident D5's clinical record revealed a physician order dated April 22, 2022, for the resident to be on contact precautions for 7 days due to the resident testing positive for ESLB (extended spectrum beta-lactamase an enzyme found in some strains of bacteria that can't be killed by many of the antibiotics that doctors use to treat infections) in her urine. An observation on April 27, 2022, at approximately 9:00 AM revealed no PPE (personal protective equipment) was present outside the resident's room to be utilized when caring for the resident. The red garbage can used to dispose of soiled PPE revealed that soiled used PPE was observed hanging out of the top of the garbage can. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Employee 5 LPN (license practical nurse) on April 27, 2022, at the time of the observation, confirmed that the resident was on transmission based precautions due to the infection in her urine. Employee 5 also verified that no PPE was available outside of the room for staff to don before entering to care for Resident D5 and that the waste was not fully contained in the red garbage can. A review of facility policy entitled Influenza Treatment last reviewed December 7, 2021, indicated that once a resident is diagnosed with influenza, staff working in the area will be reeducated on PPE and handwashing to prevent the spread of influenza. Surveillance will begin immediately and will continue until there has been no new confirmed cases for seven days and the Infection Control Nurse will complete tracking daily. A review of D6's clinical record revealed that on April 6, 2022, the resident was noted to have a fever of 99.3 degrees Fahrenheit. On April 7, 2022, the resident was transferred to the hospital for altered mental status. A progress note dated April 9, 2022, at 2:55 PM revealed that the resident returned to the facility and was positive for Influenza type A. Resident D6 resided on the C2 Unit. There was no documented evidence available at the time of the survey ending April 28, 2022, that the facility had had reeducated the staff on proper PPE and handwashing after the resident tested positive for Influenza as indicated in the facility policy. There was no daily tracking completed by the infection control nurse during the surveillance period as indicated in the policy. A review of an influenza line listing for April 2022, revealed that the facility had an outbreak of influenza and eight other residents on the C2 Unit contracted and tested positive Influenza type A. The following residents tested positive for Influenza type A: Resident C4 tested positive on April 14, 2022 Resident C6 tested positive on April 14, 2022 Resident D1 tested positive on April 14, 2022 Resident C2 tested positive on April 14, 2022 Resident C3 tested positive on April 14, 2022 Resident D2 tested positive on April 14, 2022 Resident CR4 tested positive April 15, 2022 Resident D3 tested positive April 25, 2022 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Infection Preventionist on May 28, 2022, at 12:11 PM verified that there was no reeducation of staff on PPE and handwashing when Resident D6 tested positive for Influenza. The IP also stated that she did not complete daily tracking as the policy indicated. An interview with the Director of Nursing on May 28, 2022, at approximately 2:30PM confirmed that the facility failed to consistently utilize PPE when caring for residents on transmission based precautions and failed to implement procedures to deter the spread of influenza 28 Pa Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records, select facility policy, and staff interview, it was determined that the facility failed to offer and/or provide the influenza immunization for one resident (Resident A4) and failed to offer all unvaccinated staff and residents an influenza vaccine when an outbreak occurred. Findings include: A review of facility policy entitled Influenza Treatment last reviewed December 7, 2021, indicated once a resident is diagnosed with Influenza, they will be placed on droplet precautions. Further it was indicated the facility would then offer all unvaccinated staff and residents the influenza vaccine. There was no documented evidence that the facility had offered all unvaccinated staff and residents the influenza vaccine in response to the influence outbreak in the facility. Interview with the infection preventionist on May 28, 2022, at 12:11 PM confirmed the facility failed to implement the policy for influenza treatment and did not offer all unvaccinated staff and residents the influenza vaccine. Clinical record review revealed that Resident A4 was admitted to the facility on [DATE] with diagnosis to include metabolic encephalopathy (A medical term used to describe a disease that affects brain structure or function. It causes altered mental state and confusion). A review of admission records revealed that a consent form was signed on February 15, 2022 for the facility to administer the flu vaccine to Resident A4. There was no documented evidence at the time of the survey that the facility administered the flu vaccine to Resident A4. During an interview May 28, 2022 at 12 PM, the DON confirmed that Resident A 3 did not receive the flu vaccination. 28 Pa Code 211.5 (f)(h) Clinical records 28 Pa Code 211.10 (c)(d) Resident care policies 28 Pa code 211.12 (a)(c)(d)(1)(5) Nursing Services 28 Pa code 201.29 (a) Resident rights

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 41520 Based on observations, a review of facility pest service records and staff interview, it was determined that the facility failed to maintain an effective pest control program. Findings include: Observation of Unit B-2 dining room on April 27, 2022, at 11:15 AM, revealed ants were present on the floor throughout the dining room Observation of Unit B-2 dining room on April 28, 2022, at 8:07 AM, revealed ants were present on the floor throughout dining room. Interview with Employee 2, the Director of Environmental Services on April 28, 2022, at 8:07 AM, confirmed ants were present on the floor throughout the B-2 dining room. A review of weekly pest control service documentation dated March 24, 2022, revealed the service description as Weekly Service. Under the general comments/Instructions revealed the service technician noted, Checked in with (Director of Maintenance Name). Inspected and treated for reports of ants in Dementia rooms 118- 129 and kitchen dietary office. A review of weekly pest control service documentation dated March 31, 2022, revealed the service description as Weekly Service. Under the general comments/Instructions revealed the service technician noted, Spoke with maintenance; no reports and advised to service kitchen. Inspected and treated accessible areas in kitchen, dining room, storage, and serving line for control of pests. A review of weekly pest control service documentation dated April 7, 2022, revealed the service descriptions as Weekly Service. Under the general comments/Instructions revealed the service technician noted, Per maintenance, requested kitchen to be serviced. No reports throughout floors. Inspected kitchen area storage. Replaced light trap glue boards and monitors. A review of weekly pest control service documentation dated April 13, 2022, revealed the service description as Monitoring Service. Under the general comments/ instructions revealed the service technician noted, Service technician is not allowed to go throughout the property unless issues are verbally reported to him. A review of weekly pest control service documentation dated April 14, 2022, revealed the service description as Weekly Service. Under the general comments/instructions revealed the service technician noted, Inspected kitchen area and storage. Serviced interior rodent devices. Replaced tincats glue boards as needed. No pests activity observed today. A review of weekly pest control service documentation dated April 21, 2022, revealed the service description as Weekly Service. Under the general comments/instructions revealed the service technician noted, Inspected and serviced exterior rodent devices, feeding activities observed replaced bait as needed. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Maintenance on April 28, 2022 at approximately 10:00 AM revealed there was no reports made to him regarding the ants in the B-2 dining room. The Director of Maintenance stated that when he is made aware of issues in the facility they will be reported to pest control. However, the service technician does not conduct rounds or inspect areas throughout the building for signs of pests or infestation unless the facility identifies pests in that location, which then will be treated. Review of the pest control documentation revealed there was no documentation of inspections being conducted throughout the facility or follow up to areas with existing pest identification. 28 Pa. Code 207.2 (a) Administrator's responsibility 28 Pa. Code 201.18 (e)(2)(3) Management