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	02/15/2023

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 41581 Based on observations and staff interview, it was determined that the facility failed to provide housekeeping services to maintain a clean, safe, orderly and sanitary environment in resident areas on three of three resident units (B2, C2, and D unit) Findings include: Observations of the B-2 nursing unit revealed: On February 12, 2023, at approximately 8:15 AM the unit halls were noted to have dried fluid stains, food, debris, wrappers, and dirt on the floors. The nurse's station had debris, wrappers, and dirt on the floors. Room B2-208 had a bed linen on the floor, a dried fluid stain, dirt and debris was noted throughout the room. Room B2-214 had dirt and wrappers on the floor. Room B2-217 an empty bed was noted to have a wash basin filled with a drink carton, napkins, an aluminum can and a plastic lid. Additionally, an empty plastic bag a cervial collar and miscellaneous magazines were stored on this bed, which was not made. Room B2- 219 was noted to be missing a bed, however the mattress was leaning on a recliner which was covered in linens and had a pillow wedged in the arm and the cushion, miscellaneous wheelchairs, lift pads and a urinal was noted in this room. Room B2-221 was noted to have a trash can which was overflowing, dirt, debris and wrappers were noted throughout the floor. Outside of Room B2-226 was a chair noted to have blankets and towels on the seating surface with a wheelchair lift placed on the top. Room B2-268 had black debris noted on the floor throughout the room. The B2 dining hall had dirt and debris noted throughout the room, a surgical mask was noted on the floor along with an empty coffee creamer container on the floor next to the trash can. On February 12, 2023, at approximately 12:30 PM the unit was still not cleaned. Observations of the C2 nursing unit on February 12, 2023, revealed the following: On February 12, 2023, at approximately 8:00 AM the food, debris, wrappers, and dirt were observed on the floors of the resident unit. In resident Room C2-225 food particles, food wrappers, a used sandwich bag were observed on the floor. There was toilet paper, a soiled towel and undergarments on the bathroom floor. A graduated cylinder was placed on the back of the toilet, which unlabeled and contained brown residue inside of the cylinder. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In resident Room C2-259 dirt, debris, and food were observed on the floor. There was a napkin, which appeared to be bloody, on the floor. The garbage container was overflowing. There were papers and a soiled unlabeled bedpan on the floor in the resident bathroom. In the corner of the bathroom on the floor next to the toilet next a black substance was observed on the tile wall. An unlabeled graduated cylinder was observed on the back of the toilet. Food particles, dirt, debris, and a used surgical mask on the floor of the C-2 dining room. In resident Room C2-226 a soiled band-aid coated with what appeared to be blood was observed on the floor along with dirt and debris. An unlabeled graduated cylinder was observed on the back of the toilet. Food and debris were observed on the floor of resident Room C2-223. A brown-fecal like substance was observed on the toilet and toilet seat. On February 12, 2023, at approximately 11:40 AM the observational findings remained as observed above as the C-2 unit had not been cleaned as of that time. At this time, a wheeled cart containing multiple eaten breakfast food trays was observed. The trays contained half eaten food and drinks on small flies were observed about the cart and the nursing unit. On February 13, 2023, at approximately 8:10 AM the C2 unit had not been cleaned. Food, dirt, debris, and wrappers were observed on the floor throughout the nursing unit in the halls. Dirt, debris and food wa observed on the floor of resident Room C2-259. The garbage can was overflowing in the garbage can and the same tissue, with the blood-like substance, remained in the resident's room as observed the prior date, on February 12, 2023. The floor of Resident Room C2-223 was still dirty and debris and food stuffs present on the floor. During a tour of the D-Unit/Wing, Alzheimer Dementia Unit, on February 12, 2023, at 8:01 AM, revealed several seated in the large dining room, intended for residents requiring assistance and supervision with meals, without staff oversight or supervision to assure the residents' safety. Select residents in this area were observed yelling out. Observation of the large D-Unit dining area revealed that the floor was heavily stained and debris scattered on the floor. There was a bottle of body wash without a lid and a used lidded cup with a straw with remnants of a brownish liquid left on the ledge at the entryway of the resident area. In the right corner of the dining area (to the right of the entry way), resident equipment, such as a walker and stepstool, and Christmas decorations were observed. The floor of the activity room was heavily stained, with a dried brownish-yellow substance and debris scattered about the floor. There was one sneaker on the floor. Inside an unlocked wooden cabinet, a bottle of saline and cleaning wipes were observed and a dirty towel, a worn non-skid sock, and crumbled tissues observed on the shelf. Observation of the small dining room (the dining area for more independent residents) revealed that several dining tables were left stained with brown and red substances and food particles scattered on the table tops. The floor was sticky and stained with red and brown substances that were dried onto the surface. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Drawers and upper cabinet doors were left ajar and would not close. The garbage can in this dining area was overflowing with trash. Across from the nurse's station that the was a bag of trash on the floor and there were medicine cups scattered on the floor. Outside of resident room D-123, to the right of the entry, there was a white substance dried on the floor. A foul pervasive odor permeated in the hallway outside the soiled utility room and upon entering the soiled utility room, bags of dirty linens and clothing were in bins and also on the floor. More than 12 bags of accumulated dirty linens and clothing were observed. Resident care equipment, including a chair scale, two floor mats, and leg rests were scattered throughout the soiled utility room. Cabinets and drawers were left ajar, and many were in ill-repair. Interview with Employee 7, RN Unit manager/Supervisor at that time confirmed the observations and stated that housekeeping should pick up the dirty linens and clothing daily. Interview with Employee 8, an agency LPN, on February 12, 2023, at 8:55 AM, revealed that on the weekend housekeeping staff was often not seen on the resident unit during an entire shift. Further observation of D-Unit on February 13, 2023, at 8:15 AM, revealed a dark-sticky substance on the floor inside of resident room D-110. In resident room D -127 the small bottom screen was missing from the window and there were cups, food debris, and cups on the floor underneath the beds. Interview with the Nursing Home Administrator on February 15, 2023, at approximately 3:30 PM confirmed that the facility is to be maintained in a clean and sanitary environment on a daily basis. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on review of clinical records, select facility policy and investigative reports, and resident and staff interview, it was determined that the facility failed to ensure that three (Residents 67, Resident 5, and Resident 74) residents out of 29 sampled residents were free from physical abuse resulting in signifcant bruising to one resident (Resident 74). Findings including Review of a facility policy entitled Abuse Protection with a policy review date of February 10, 2023, indicated that the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of property. The facility shall have processes in place to include screening, training, prevention, identification, protection, investigation, reporting, and response to allegations of potential or actual abuse and neglect. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse facilitated or enabled through the use of technology. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse includes hitting slapping, pinching, and kicking. Our facility is committed to protecting our residents from abuse. Prevention of abuse is to include monitoring residents with needs and behaviors. Review of Resident 67's clinical record revealed that he was admitted to the facility on [DATE], with diagnoses of sequelae of cerebral infarction [occurs when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen and nutrients], dysphagia (difficulty swallowing), aphagia [is a comprehension and communication (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain], major depressive disorder, anxiety disorder. A review of Resident 67's annual Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 14, 2022, revealed that the resident was severely cognitively impaired with no behavioral symptoms identified. Review of Resident 67's care plan dated May 15, 2019, and revised on October 21, 2022, revealed that the resident had the potential to exhibit distressed mood, and behavior symptoms as evidence by aggression when attempting to redirect, agitation as evidence by throwing objects at staff, going into other rooms, pacing, yelling and arguing with staff, and physical aggression exhibited toward another resident. Planned interventions to manage the resident's behaviors was every 15-minute checks, approach in a calm and unhurried manner, keep excited or noisy residents out of reach, as loud noise tends to exacerbate aggressive behaviors, and observe for changes in mood/behavior (i.e., aggression when attempting to redirect, agitation as exhibited by throwing objects at staff, going into others rooms, pacing, yelling at\arguing with staff, flat affect, physical aggression toward others) and overall functioning and document. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing progress notes dated October 21, 2022, at 7:43 PM, revealed that at approximately 3:05 PM, Resident 5 grabbed Resident 67, which caused Resident 67 to turn and strike Resident 5 three times on the top of the head. At that time, staff separated the two residents and redirected the residents back to their room. Every 15 minute checks were to be conducted of Resident 67. Review of Resident 74's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to have included dementia without behaviors disturbance, anxiety, unsteady on feet, muscle weakness, lack of coordination, and dysphagia (difficulty swallowing). A review of Resident 74's 5-Day Minimum Data Set assessment dated [DATE], revealed that the resident was severely cognitively impaired. Review of Resident 74' s care plan dated August 26, 2022, and revised on September 14, 2022, identified that the resident had the potential to wander with planned interventions for staff to be aware of the resident's tendency to wander, attempt to redirect wandering behaviors, and observe the resident's whereabouts throughout the day. Nursing progress notes dated October 3, 2022, at 7:05 AM, revealed that the resident was awake all night and was found to be sitting in room D-109 (not the resident's room) and refused to leave. Later on, in the shift the resident was sitting near station, all of a sudden took his hand and swept a full drink and items all over floor and was threatening staff. Nursing notes dated October 14, 2022, at 1:56 AM, revealed that Resident 74 was awake at 11 PM and seated at the nurses station. Several female residents were wandering around the area and Resident 74 got up and was grabbing at the female residents, trying to get them to go with him. The resident continued to threaten staff and wouldn't allow them to come near them. Resident 74 threatened to kill staff if they went near. He was redirected away from the others and was angry and threatening to call the police to have staff arrested. Staff attempted to provide a snack, but he refused. Resident 74 continued to display aggressive and threatening behaviors and wandering behavior as noted in nursing documentation on October 17, 2022, at 4:47 AM, on October 28, 2022, at 4:26 AM, and on November 7, 2022, at 2:34 AM. An incident report dated November 8, 2022, at 6:57 AM, revealed that while in their room Resident 74 struck his roommate, Resident 67, in the chest and then Resident 67 pushed him {Resident 74} away causing him to lose his balance and fall landing on his right side. No injuries were noted at that time and Resident 74 was placed on every 15-minute checks. A nursing progress note completed by Employee 17, a RN, dated November 11, 2022, at 7:35 AM, revealed that during rounds Employee 16 was giving care to resident and found a bruise on right hip and right chest. The bruise size, to his right hip measured 15.0 cm long x 8.0 cm wide and the bruising to the right chest measured 8.0 cm in length x 8.0 cm in width. The resident stated that he had no pain during ambulation and no pain in his right chest area. Orders for an x-ray was offered to resident, but refused, MD and RP called and informed of same. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An incident report, completed by Employee 15, an LPN, dated November 14, 2022, at 5:12 AM, revealed that while Employee 16, a nurse aide, was toileting Resident 74 she observed bruising on his right hip and down to his mid leg and bruising to the resident's right chest. Resident 74 was not able to recall what happened. Employee 15 noted that the resident was assessed, bruising noted to be from a fall related to an incident with another resident, Resident 67. The facility failed to protect residents from physical abuse and failed to effectively monitor and supervise residents with known episodes of aggressive behaviors to prevent resident to resident altercations and injuries. During interview with the Director of Nursing (DON) on February 15, 2023, at 12:00 PM, confirmed that the facility failed to consistently monitor residents with known physical aggressive behaviors to prevent resident to resident abuse. 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition 28 Pa. Code 201.29(a)(c)(d) Resident rights 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(e)(1) Management

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records and select investigative reports and staff interview it was determined that the facility failed to timely report allegations of resident abuse for one of 29 residents sampled (Resident 5). Findings include: Clinical record revealed that Resident 67 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (stroke) and anxiety. An annual MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 14, 2022, revealed Resident 67 was severely cognitively impaired and required assistance of staff for activities of daily living. A resident's current care plan identified that the resident had the potential to exhibit a distressed mood and behavior symptoms as evidenced by aggression when attempting to redirect, agitation as evidenced by throwing objects at staff, going into other resident rooms, pacing and yelling at/arguing with staff. Interventions to include, approach in a calm and unhurried manner, keep excited or noisy residents out of reach of resident as loud noise tends to exacerbate aggressive behaviors, observe for changes in mood/behavior (i.e.:aggression when attempting to redirect,Agitation as evidenced by throwing objects at staff, going into others rooms, pacing, yelling at\arguing with staff, flat affect, physical aggression toward others. Nursing documentation dated October 21, 2022 at 7:43 P.M. revealed that approximately at 3:05 P.M., Resident 67 was involved in an incident during which Resident 5 grabbed Resident 67, which caused Resident 67 to turn and react on his own by striking Resident 5, three times on top of her head. At this time this nurse and a nurse aide separated the residents and Resident 67 was redirected to his room was placed on 15 minute checks. The facility did not report this incident of physical abuse of Resident 5 to the State Survey Agency until discovered by the survey team during the survey ending February 15, 2023. In response to surveyor inquiry, a facility investigation dated as completed on February 13, 2023, during the survey ending February 15, 2023, revealed that an incident of resident to resident abuse occurred on October 21, 2022, at 3:05 PM Resident 5, a severely, cognitively impaired resident was seated in her wheelchair while being pushed by another resident in the hallway of the resident unit. Resident 67 was ambulating around Resident 5 when Resident 5 grabbed Resident 67's shirt. Resident 67 reacted by punching Resident 5 on the head three times. The residents were separated by staff. A review of a witness statement dated October 21, 2022, no time indicated, Employee 20, a nurse aide, stated that Resident 5 was in her wheelchair in the hallway when a resident pushed her wheelcahir from behind. Resident 67 was walking by and Resident 5 grabbed his shirt. Resident 67 struck Resident 5 on the top of her head with a closed fist three times. The incident happened at 3:05 P.M. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social services note dated October 21, 2022, at 4:30 PM revealed that nursing made the Social Worker aware Resident 67 struck resident a female resident, Resident 5. Social Service staff made a visit to Resident 67 to discuss the incident. The social service worker Engaged in light conversation with Resident 67, who was non-verbal during visit, but did indicate, by nodding, that he was able to recall incident. The social service worker discussed and educated Resident 67 on appropriate behaviors towards others and Resident 67 expressed understanding of same. During an interview February 14, 2023 at 2 P.M., the Director of Nursing confirmed that the incident of resident to resident abuse was not reported timely to the State Survey Agency. 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition 28 Pa. Code 201.14 (c)(e) Responsibility of Licensee

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41520 Based on clinical record review and staff interview, it was determined that the facility failed to ensure necessary resident information was communicated to the receiving health care provider for three transferred residents out of 29 sampled residents (Residents 86, 93 and 107). Findings include: A review of the clinical record of Resident 86 revealed that the resident was transferred and admitted to the hospital on January 22, 2023 and returned to the facility on [DATE] and was transferred and admitted to the hospital on February 3, 2023 and returned to the facility on [DATE]. A review of Resident 93's clinical record revealed the resident was transferred from the facility and admitted to the hospital on December 2, 2022, and returned to the facility on [DATE]. A review of Resident 107's clinical record revealed the resident was transferred from the facility and admitted to the hospital on January 7, 2023, and returned to the facility on [DATE]. Further review of the above clinical records revealed no documented evidence of the information communicated to the receiving health care facility upon the residents' transfer to the hospital. Interview with the Nursing Home Administrator on February 15, 2023, at 3:30 PM, revealed that the facility was unable to provide documented evidence that all special instructions or precautions for ongoing care, as appropriate, and comprehensive care plan goals were communicated to the receiving health care facility. 28 Pa. Code 201.29(f)(g)(h) Resident rights 28 Pa. Code 211.5 (f) Clinical records

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of the Resident Assessment Instrument Manual and clinical records, and staff interviews, it was determined that the facility failed to transmit Minimum Data Set (MDS) assessments to the required electronic system, the CMS Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, within the required time frame for one of 29 residents reviewed (Resident 339). Findings included: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (Section V0200C2 + 14 days), and all other assessments must be submitted within 14 days of the MDS Completion Date (Section Z0500B + 14 days). A review of Resident 339's clinical record revealed that she was admitted to the facility on [DATE]. An Admission 5-Day MDS assessment was scheduled for February 6, 2023, and was not completed and submitted until surveyor inquiry on February 12, 2023. The assessment was triggered in Point Click Care (PCC - electronic health record) indicted that the assessment was 3-days overdue. Interview with the Registered Nurse Assessment Coordinator (RNAC) on February 13, 2023, at 11:18 AM, confirmed that Resident 339's admission MDS assessment was late and was not submitted timely according to the MDS submission timeframe. 28 Pa. Code 211.12 (c) Nursing Services 43944 Based on review of the Resident Assessment Instrument Manual and clinical records, and staff interviews, it was determined that the facility failed to transmit Minimum Data Set (MDS) assessments to the required electronic system, the CMS Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, within the required time frame for one of 29 residents reviewed (Resident 339). Findings included: (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (Section V0200C2 + 14 days), and all other assessments must be submitted within 14 days of the MDS Completion Date (Section Z0500B + 14 days). A review of Resident 339's clinical record revealed that she was admitted to the facility on [DATE]. An Admission 5-Day MDS assessment was scheduled for February 6, 2023, and was not completed and submitted until surveyor inquiry on February 12, 2023. The assessment was triggered in Point Click Care (PCC - electronic health record) indicted that the assessment was 3-days overdue. Interview with the Registered Nurse Assessment Coordinator (RNAC) on February 13, 2023, at 11:18 AM, confirmed that Resident 339's admission MDS assessment was late and was not submitted timely according to the MDS submission timeframe. 28 Pa. Code 211.12 (c) Nursing Services

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 26142 Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined the facility failed to timely complete quarterly MDS assessments for one out of 29 residents reviewed (Resident 189). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that an admission MDS assessments were to be completed no later than 14 days following admission, and Quarterly assessments to be completed no later than the ARD date (Assessment Reference Date (ARD) refers to the last day of the observation {or look back} period that the assessment covers for the resident) plus 14 calendar days. It is important to note that even nursing homes that have been granted an RN waiver under 42 CFR 483. 35(e) must provide an RN to conduct or coordinate the assessment and sign off the assessment as complete Coding Instructions For section Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date must be equal to the latest date at Z 0400 or later than the date(s) at Z0400, which documents when portions of the assessment information were completed by assessment team members. If for some reason the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should use the actual date that it is signed. The RN assessment coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals. Section Z0400 indicates Signatures of Persons Completing the Assessment; If an individual who completed a portion of the MDS is not available to sign it (e.g., in situations in which a staff member is no longer employed by the facility and left MDS sections completed but not signed for), there are portions of the MDS that may be verified with the medical record and/or resident/staff/family interview as appropriate. For these sections, the person signing the attestation must review the information to assure accuracy and sign for those portions on the date the review was conducted. For sections requiring resident interviews, the person signing the attestation for completion of that section should interview the resident to ensure the accuracy of information and sign on the date this verification occurred. Section Z0500 indicates the Signature of RN Assessment Coordinator Verifying Assessment Completion Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete. Resident 189's quarterly MDS Assessment with an ARD date of January 26, 2023, revealed that the RNAC signed Sections' C, D as completed on January 24, 2023, and Sections E, F, Q and S as completed on January 26, 2023, however Sections A, B, G, GG, H, I J, L, M, N, O and P were not completed until February 13, 2023. (continued on next page)

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Aventura at Terrace View	108 Terrace Drive Olyphant, PA 18447

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview February 14, 2023 at 11 A.M. the facility RNAC confirmed that the resident's quarterly MDS Assessment was timely completed. 28 Pa. Code 211.12(c) Nursing services

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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 review of clinical records and the Resident Assessment Instrument and resident and staff interviews, it was determined that the facility failed to ensure that the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of two residents out of 29 sampled (Resident 123 and 138). Findings include: A review of Resident 123's Admission MDS assessment dated [DATE], revealed in Section A1000, Race/Ethnicity, that the resident was noted to have NO marked for all options available in respect to race/ethnicity. Interview with Resident 123 on February 12, 2023 at approximately 11:30 AM revealed that the resident stated that her race is black A review of Resident 138's Discharge MDS assessment dated [DATE], revealed in Section A2100. Discharge Status, the option 03. Acute hospital was selected. Review of Resident 138's clinical record revealed a Social Service note dated November 17, 2022 at 1422 (2:22 PM) noting, [Resident name} discharged to home today as scheduled. Interview with the Nursing Home Administrator on February 15, 2023, at 3:00 PM confirmed that the residents MDS assessments were inaccurate. 28 Pa. Code 211.5(g)(h) Clinical records. 28 Pa. Code 211.12(c)(d) (1)(3)(5) Nursing Services

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **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 address a resident's behavioral symptoms on the baseline care plan of one of 29 sampled residents (Resident 189). Findings include: Clinical record review revealed Resident 189 was admitted to the facility on [DATE], with diagnoses to include a history of a stroke, diabetes and chronic kidney disease from a sister facility. A review of the resident's preadmission paperwork from the prior facility revealed the following the nursing documentation: On January 10, 2023, at 3:22 PM Resident 189 splashed a drink at the nurse in the hallway and made derogatory remarks towards care workers and other residents. On January 12, 2023, at 3:15 PM Resident 189 threatened to throw coffee at the nurse, verbal redirection made. Resident continued to exhibit non-compliant behaviors and continued to threaten to splash coffee according to the nursing entry. On January 12, 2023, at 3:26 PM revealed Resident 189 continued to antagonize staff when in the hall. On January 13, 2023, at 3:29 PM Resident 189 threatened care workers stating, I'm going to knock you the f. **k out. Grabs the nurses wrist while changing bandages and refuses to let go while continuing to make threatening statements. On January 13, 2023, at 4:26 PM revealed that Resident 189 splashed milk at the nurse and claimed to have dumped milk on the medication cart. There was milk found on the med cart, but not witnessed. A review of an addission MDS assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated January 26, 2023, revealed that Resident 189 was moderately, cognitively impaired with a BIMS score of 8 (a score of 8-12 indicating moderate impairment). There were no noted behavioral symptoms identified on this MDS assessment although known to the facility as evidenced by the nursing documentation from the facility's sister facility prior to the resident's admission. A review of the resident's baseline admission care plan, dated January 18, 2023, revealed no reference to any psychosocial or behavioral issues. did not contain any mention of psycho social or behavioral issues. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence at the time of the survey ending February 15, 2023, that the resident's behavioral symptoms, that were known to the facility based on the resident's pre-admission nursing documentation from the facility's sister facility, had been identified and addressed on the resident's care plan. During an interview February 13, 2023, at 1 PM the Social Services director confirmed the resident's known and documented behaviors were not identified on the resident's MDS assessment and were not addressed on the resident's care plan. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing Services 28 Pa. Code 211.11 (d)(e) Resident care plan

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records and select incident report, and staff interview, it was determined that the facility failed to revise a comprehensive plan in response to falls to meet the current safety needs of one one resident out of 18 reviewed (Resident 42). Findings include: A review of Resident 93's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses of metabolic encephalopathy (chemical imbalance in the blood that affects the brain which can cause loss of memory and difficulty coordinating motor tasks) and muscle weakness. A review of the resident's comprehensive plan of care, last revised by the facility, February 3, 2022, revealed that the resident was at risk for falls related to limited mobility and weakness. A review of a progress note dated November 29, 2022, 2:27 AM indicated that the resident had an unwitnessed fall at approximately 1:00 AM. A review of an incident report dated November 29, 2022, revealed the resident was found on the floor, in front of the door, lying on his right side. The report noted that a rehabilitation screen was completed and a new intervention for a bariatric bed was recommended to improve safety. A progress note dated December 2, 2022, at 5:18 AM, revealed that staff found the resident seated on the floor. The resident had attempted to self-transfer to his wheelchair unassisted. A review of an incident and accident report dated December 2, 2022, indicated that the resident had an unwitnessed fall and was found sitting on the floor after attempting to self-transfer to his wheelchair alone prior to him receiving a shower. The report noted that a rehabilitation screen was completed and a new intervention for a clip alarm for safety was recommended. The facility failed to revise and update the resident's at risk for falls care plan with these new interventions, the bariatric bed and clip alarm, after the falls that had occurred on November 29, 2022, and December 2, 2022 . An interview on February 15, 2023, at approximately 3:30 PM, with the Nursing Home Administrator confirmed the resident's care plan had not been reviewed and revised in response to the resident's falls in the facility to ensure any additional planned interventions were incorporated into the resident's plan of care and consistently implemented by staff. 28 Pa. Code 211.12(a)(c)(d)(1)(3)(5) Nursing Services. 28 Pa. Code 211.11(d)(e) Resident Care Plan.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41520 Based on a review of clinical records and staff and resident interview it was determined that the facility failed to develop and implement an individualized discharge plan for three of three residents reviewed for discharge planning (Resident 13, 138 and 118). Findings Include: A review of the clinical record of Resident 13 revealed admission to the facility on [DATE], for orthopedic aftercare, bladder disorder, and muscle weakness. An admission MDS dated [DATE] revealed that the resident's goal was to be discharged to the community. Review of Resident 13's care plan revealed a discharge plan, initiated on January 9, 2023. This discharge plan was not revised or updated as of the time of the survey ending February 15, 2023. The resident had a planned discharge date of [DATE] as of the date of the survey. A review of the clinical record of Resident 138's revealed admission to the facility on [DATE], with diagnoses including acute and chronic respiratory failure, coronary artery disease, and history of falling. Resident 138's admission MDS assessment dated [DATE], revealed that the resident's goal was to be discharged to the community. A review of the resident's care plan revealed no discharge plan had been developed, revised or updated. The resident was discharged and returned to the community on November 17, 2022. Review of Resident 118's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses to have included unspecified dementia without behavioral disturbance, visual and auditory (hearing) hallucination, and major depression. During an interview with Resident 118 on February 12, 2023, at 12:40 PM, revealed that the resident stated that she would like to be discharged and had been asking to speak with her social worker for weeks about looking into potential facilities to be transferred to in New Jersey. A review of Resident 118's comprehensive person-centered plan of care failed to reveal that discharge planning was addressed. Through survey ending February 15, 2023, at 3:00 PM, the facility was unable to provide any documented evidence that discharge planning was addressed with Resident 118 or the resident's representative. During an interview on February 15, 2023, at 3:00 p.m. the Director of Nursing confirmed there was no documented evidence of discharge planning for Resident 118 and Resident 138 or revisions and updates to Resident 13's discharge plans . 28 Pa. Code 201.25 Discharge policy 28 Pa. Code 211.11 (d)(e) Resident care plan (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.29 (i)(j) Resident rights.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records, select facility policy and incident reports and staff interviews it was determined that the facility failed to consistently conduct ongoing nursing assessments of a resident physical status and potential signs of head injury after unwitnessed falls, in accordance with facility policy and standards of practice, for one resident out of 29 sampled (Resident 93) and failed to provide person-centered care in coordination outside medical providers to meet the treatment goals of one of 29 sampled resident (Resident 48). Findings included: A review of the facility policy entitled Neurological Assessment last reviewed by the facility February 2023 revealed a neurological assessment are performed following an unwitnessed fall. A review of Resident 93's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses which included metabolic encephalopathy (chemical imbalance in the blood that affects the brain which can cause loss of memory and difficulty coordinating motor tasks) and muscle weakness. A review of a progress note dated November 29, 2022, 2:27 AM indicated that the resident had an unwitnessed fall at approximately 1:00 AM. The incident and accident report dated November 29, 2022, revealed that the resident was found on the floor in front of the door lying on his right side. There was documented evidence that nursing staff conducted neurological assessments according to the fall protocol and standards of practice for unwitnessed falls. A review of a progress note dated December 2, 2022, at 5:18 AM, revealed that staff found the resident sitting on the floor after attempting to self-transfer to his wheelchair unassisted. The incident and accident report dated December 2, 2022, indicated that the resident had an unwitnessed fall and was found sitting on the floor after attempting to self-transfer to his wheelchair. There was no documented evidence that nursing staff conducted the neurological assessments according to fall protocol and standards of practice for unwitnessed falls. During an interview on February 14, 2023, at approximately 2:00 PM, the Director of Nursing (DON) verified that the facility failed to conduct neurological assessments after unwitnessed falls according to facility policy and consistent with professional standards of practice. Clinical record review revealed Resident 48 was admitted to the facility on [DATE] with diagnoses to include coronary artery disease, unstable angina and atrial fibrillation. A physician order dated August 22, 2022, was noted for the resident to have a a follow-up appointment with the cardiologist on February 8, 2023, at 9:15 A.M. at cardiology office. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence in the resident's clinical record Resident 48, at the time of the survey ending February 15, 2023, attended the cardiology appointment on February 8, 2023, as ordered by the physician. A physician order dated February 24, 2023, at 11:13 A.M. revealed that the resident had an appointment scheduled on March 8, 2023 at 3:30 PM with hospital cardiology with a cardiologist. There was no documented evidence at the time of the survey ending February 15, 2023, to indicate whey the resident did not attend the cardiology appointment February 8, 2023. There was no documented evidence at the time of the survey why the resident's cardiology appointment was not rescheduled until February 24, 2023, 16 days after the first missed appointment. During an interview on February 15, 2023 at 11 AM the Director of Nursing was unable to explain why the resident did not attend the cardiology appointment on February 8, 2023, or the delay in rescheduling the missed appointment to ensure the resident received timely cardiology care to meet the resident's treatment goals. 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing services 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 201.21 (b) Use of outside resources

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41520 Based on observation, a review of clinical records and select facility policies, observation and staff and resident interview it was determined that the facility failed to provide nursing services to maintain mobility and current level of functioning for one resident (Resident 63) and failed to apply a prescribed therapeutic device to provide support and maintain proper positioning was two residents (Resident 51 and 24) out of 29 sampled. Findings include: A review of the clinical record revealed that Resident 63 was admitted to the facility on [DATE], had diagnoses to include monoplegia of lower limb following cerebral infarction affecting right dominant side and muscle weakness. The resident had a physician order dated March 4, 2022, for a RNP as appropriate for Active and Passive ROM. This order did not include the details, frequency or other components of the Restorative Nursing Program. A review of the resident's current plan on care, conducted during the survey ending February 15, 2023, did not indicate that the resident was receiving a Restorative Nursing Program (RNP). Interview with the resident on February 13, 2023, at approximately 9:30 AM revealed that there resident voiced concerns regarding decreased mobility. The resident stated that staff assist with activities of daily living, but do not perform any range of motion exercised for her, The resident stated that only when I am on therapy does she receive the exercises. Interview with the Director of Nursing on February 15, 2023 at approximately 3:30 PM confirmed there was no documented evidence that the resident was receiving a restorative nursing program for passive and active range of motion. A review of the clinical record of Resident 51 revealed admission to the facility December 17, 2022, with diagnoses, which included hemiplegia (paralysis on one side of the body) following cerebral infarction (stroke). A physician order dated January 4, 2023, was noted for a right palm protector (device applied to maintain positioning and prevent fingernails from contacting the palm of the hand) on at all times with the exception of hygiene and range of motion. Nursing to check skin integrity every shift. According to the Documentation Survey Reports for January 2023 and February 2023, there was no documented evidence that the staff were applying a right palm protector as ordered. Review of Resident 51's January 2023 Documentation Survey Report revealed the task for staff to place a rolled washcloth in the resident's right hand at all times with the exception of hygiene and range of motion every shift. According to the task completion report for January 2023, staff failed to complete this task on 56 occassions this task was not completed 46 times. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and the February 2023 Documentation Survey Report revealed the task for placing a rolled washcloth in the right hand was not completed 21 times. Observation of Resident 51 on February 12, 2023, at 11:40 AM revealed the right palm protector was not in place and was not observed in the resident's room. There was no rolled washcloth observed in the right resident's hand at that time. An interview with Resident 51 on February 12, 2023, at the time of the observation revealed that the resident stated that he normally does not have a palm protector on his right hand. The resident stated that infrequently, staff will try to put a rolled- up wash cloth in his hand, but it usually falls out and they don't put it back it. The resident stated that it's rare when staff actually place the washcloth in his hand. Another observation of the resident on February 14, 2023, at 8:12 AM revealed that the resident's palm protector was not in place nor a rolled washcloth. An additional observation on February 14, 2023, at 8:20 AM revealed the resident's palm protector was still not in place nor a rolled washcloth. An interview with Employee 24 OT (Occupational Therapist) on February 14, 2023, at approximately 9:00 AM revealed the employee stated a palm protector and a rolled washcloth are not the same, whereas the the palm protector wraps around the thumb and velcros into place and a rolled washcloth is just rolled up and placed in the palm to prevent the fingers from touching the palm. Review of Resident 24's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included dysphagia (difficulty swallowing), anoxic brain damage (damage caused by lack of oxygen to the brain), and quadriplegia (paralysis of the arms and legs). A physician order dated May 20, 2022, was noted for a left and right hand rolls on at all times and off for range of motion and hygiene. Observations of the resident on February 12, 2023, at approximately 8:20 AM revealed the resident's right and left hand rolls were not in place. An observation of the resident on February 14, 2023, at 8:15 AM revealed a folded piece of gauze in the resident's left hand. The gauze was not place in the resident's palm, but was between her thumb and first finger. No other hand rolls were observed at that time. An interview with the Director of Nursing and Nursing Home Administrator on February 15, 2023, at approximately 3:30 PM confirmed that the facility failed to apply therapeutic devices as ordered by the physician to prevent contractures and decreases in range of motion while providing support and proper positioning for Resident 51 and 24. 28 Pa. Code: 211.5(f) Clinical records 28 Pa Code 211.12 (a)(c)(d)(3)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 26142 Based on review of clinical records and select incident reports and staff interview it was determined that the facility failed to timely develop and implement individualized safety measures and provide necessary assistance devices and staff supervision of a resident with known unsafe positioning and functional deficits to prevent a fall with serious injuries, a fractured spine and facial lacerations, for one resident out of 29 sampled (Resident 189). Findings include: A review of the clinical record revealed that Resident 189 was admitted to the facility on [DATE], with diagnoses to include, history of cerebral vascular accident (stroke) and transient ischemic attack (TIA), contracture of the right and left knee and peripheral vascular disease. An admission MDS assessment dated [DATE] (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) revealed Resident 189 was moderately cognitively impaired with a BIMS (tool used to screen and identify the cognitive condition of residents upon admission into a long term care facility) score of 8 (8 to 12 indicating moderate cognitive impairment) and required extensive assistance of staff for activities of daily living and utilized a wheelchair for ambulation. The resident's plan of care, dated January 18, 2023, indicated that the resident was at risk for falls related to impaired safety awareness, weakness and history of falls. Interventions planned were to use bed and chair alarms and a chair with seating equipment as ordered. However, the care plan did not identify the specific seating equipment ordered. Staff were also to encourage the resident to take frequent rest periods. The care plan did not address the need for staff supervision or monitoring of the resident. A physical therapy evaluation dated January 18, 2023, revealed that Resident 189 was at risk for falls. The resident had impaired range of motion in his right upper and lower extremity and his sitting and standing balance was fair. The resident's gait analysis was described as exhibiting a foreward lean of trunk and excessive knee flexion, which are associated with the underlying causes of lack of selective control and range of motion. The resident's risk factors for falls were due to documented physical impairments and associated functional deficits. Therapy concluded that the resident was at risk for falls and had a further decline in function and increased dependency on care givers. A review of a facility investigation report dated February 3, 2023, 2:41 P.M., revealed that staff found the resident on the floor in the hallway between his room and the nurses station. Staff heard the resident yell and found him on the floor. The report indicated that Resident 189 responded I fell over. The facility's investigation indicated that Employee 18, a nurse aide, had seen the resident seated in a wheelchair adjacent to nurses station 5 minutes prior to the resident's fall. However, Employee 18's witness statement included in the investigation was contradictory this account. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The investigation report noted that the resident sustained a laceration to his mid forehead measuring 4 cm x 0.2 cm, two abrasions to his nasal bridge measuring 1 cm x 0.3 cm on each side of the nasal bridge, and right knee abrasions measuring 3 cm x 3 cm, 0.4 cm x 0.4 cm, 0.3 cm x 0.3 cm and 2 cm x 0.3 cm. The attending physician was called and the resident was sent to the emergency room for evaluation and treatment. A review of a witness statement dated February 3, 2023, no time indicated Employee 18 (nurse aide) stated that Resident 189 fell out of his wheelchair in the hallway and the fall was unwitnessed. She stated that she last saw Resident 189 at 12 PM, when she last provided toileting care to the resident, approximately two hours and 41 minutes before the resident fell . A review of a witness statement dated February 3, 2023, no time indicated, from Employee 19 (LPN) indicated that she had just walked onto the resident floor after her break. The last time she saw the resident was just prior to leaving the floor for her break and he was seated in his wheelchair in the hallway. At that time, Employee 19 said Resident 189 was leaning forward in the wheelchair. Employee 19's statement also noted that she had observed {Resident 189} leaning foreward in his wheelchair many times and she had warned him many times to sit back in the chair. A review of nursing documentation dated February 3, 2023, at 2:42 PM revealed that Resident 189 remained alert. A large amount of bleeding was observed from his forehead laceration and scant blood from nose abrasions. Pressure was applied to his forehead. No further bleeding. Steristrips were also applied to prevent further bleeding and to protect subcutaneous tissue. Nursing documentation dated February 3, 2023, at 3:30 PM revealed that the resident was transferred out to the hospital via ambulance stretcher with three attendants. A nurses note dated February 4, 2023, 12 AM, indicated that nursing spoke to hospital emergency staff and Resident 189 will be admitted with a Primary L2 subacute fx (fractured spine) Hospital documentation dated February 3, 2023, revealed that an x-ray and CT scan (diagnostic imagining study) revealed an L2 (lumbar spine) sub acute fracture and a facial laceration repair with multiple sutures. Neuro surgery was consulted and a brace was ordered for Resident 189 to wear when upright and out of bed. His forehead and nasal lacerations were repaired with sutures. The resident was readmitted to the facility February 8, 2023. There was no documented evidence that the facility had promptly addressed the resident's known unsafe behavior of leaning in the chair as documented by nursing and therapy staff. The resident's care plan failed to identify specific seating arrangements and/or necessary devices to maintain the resident's safety while seated in a chair and self-propelling in a wheelchair. The facility's investigation failed to indicate if a chair alarm was present on the resident's chair at the time of the fall or had sounded to alert staff. The facility also failed to demonstrate the provision of sufficient staff supervision and monitoring of the resident at risk for falls with known functional deficits to prevent this fall with serious injuries. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview with the Director of Nursing on February 14, 2023 at approximately 2 PM failed to provide evidence that the facility had timely implemented individualized and effective safety measures while the resident was seated in the wheelchair and when the resident was self-propelling herself in the wheelchair to prevent accidents and injuries. 28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10 (a)(d) Resident care policies 28 Pa. Code 211.11 (d)(e) Resident care plan

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41520 Based on observations, review of clinical records and select facility policy, resident and staff interview, it was determined that the facility failed to thoroughly assess and evaluate bladder function and implement individualized approaches to restore normal bladder function to the extent possible for one resident with urinary incontinence (Resident 63) out of 29 sampled residents and failed to provide services to prevent complications related to the use of indwelling urinary catheters for three residents (Resident 10, 13, and 76) out of 29 sampled. Findings include: Review of facility policy entitled, Urinary Continence and Incontinence- Assessment and Management , last reviewed February 2023, revealed the staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. The policy indicates as part of its assessment, nursing staff will seek, and document details related to continence. Relevant derails include the following: a. Voiding patterns (frequency, volume, nighttime or daytime, quality of stream etc.) b. Associated pain or discomfort(dysuria); and c. Types of incontinence: 1. Stress- occurs with coughing, sneezing, laughing, lifting, etc. 2. Urge-overactive or spastic bladder 3. Mixed- stress incontinence with urgency 4. Overflow-related to blocked urethra or weak bladder muscle 5. Transient-temporary related to a potentially reversible or improvable condition 6. Functional- related to inability to get to the toilet in time due to physician or cognitive impairment or external obstacles. A review of the clinical record revealed that Resident 63 was admitted to the facility on [DATE], with diagnoses to include MONOPLEGIA OF LOWER LIMB FOLLOWING CEREBRAL INFARCTION AFFECTING RIGHT DOMINANT SIDE and muscle weakness. An Admission Minimum Data Set Assessment (MDS -a federally mandated standardized assessment completed at specific intervals to define resident care needs) dated February 2, 2022, indicated that the resident was cognitively intact, dependent on staff for activities of daily living (ADLs- the basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring and repositioning) and was frequently incontinent of urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 63's Admission Bladder Evaluation, Section J., dated January 26, 2022, was blank and there was no documented assessment of the resident's bladder function. Interview with the Director of Nursing on February 14, 2023, at approximately 10:30 AM revealed that upon admission, an assessment of bladder function should be performed and a 3-day Bowel and Bladder should be completed to document trends. However, there was no 3-day Bowel and Bladder available at the time of the survey ending February 15, 2023, upon Resident 63's admission on January 26, 2022. Resident 63's current plan of care, dated February 23, 2022, indicated that the resident had functional bladder incontinence related to activity intolerance, disease process and impaired mobility. Interventions planned were to use size XL disposable brief, check the resident every 2 hours, and as required, for incontinence and monitor and document for signs symptoms of a urinary tract infection. Interview with Resident 63 on February 13, 2023, at 9:38 AM revealed that the resident stated that do not check her every two hours for toileting needs and that she is incontinent because staff do not respond timely to her toileting needs when she activates the call bell requesting staff assistance with toileting. The resident stated when she feels to urge to urinate, she rings the call bell, and then waits anywhere from 30 minutes to over an hour. The resident stated so of course, I'm incontinent. I can't hold it that long and I need staff assistance with toileting. A review of Resident 63's every 2 hour check in change dated February 2023 revealed no documented evidence that staff had performed this task on 100 occassions out of 168 opportunities as scheduled from February 1, 2023, to February 14, 2023. Interview with the Director of Nursing on February 15, 2023, at 3:30 p.m. confirmed that the facility failed to provide this resident with timely staff assistance and necessary care and services to maintain urinary continence and prevent decline in bladder function. A review of clinical record revealed Resident 10 was admitted to the facility on [DATE], with diagnoses which, included obstructive and reflux uropathy (urine cannot drain through the urinary tract). A physician orders initially dated April 12, 2022, was noted for the resident's use of a Foley catheter (tube inserted into the bladder to drain urine) to straight drainage. Observations of the resident on February 12, 2023, at approximately 8:30 AM revealed the resident was lying in bed. The resident's Foley catheter bag was lying directly on the floor and was not in a privacy bag. An additional observation of the resident on February 13, 2023, at 7:57 AM revealed the resident's Foley catheter bag was again lying directly on the floor and not in a privacy bag. A review of the clinical record of Resident 13 revealed admission to the facility on [DATE], with orthopedic aftercare, bladder disorder, and muscle weakness. A review of physican's orders, initially dated January 2, 2023, indicated that the resident had a Foley catheter to straight drainage. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of the resident on February 12, 2023 at approximately 9:00 AM and 12:45 PM revealed the residents Foley catheter bag was lying on the floor, a privacy bag was in place, however the catheter bag was not completely contained within the bag and was lying directly on the floor. A review of clinical record revealed Resident 76 was admitted to the facility on [DATE], with diagnoses, which included obstructive and reflux uropathy and chronic kidney disease. A physician order was noted January 13, 2023, for a Foley catheter to straight drainage. Observations of the resident on February 12, 2023, at 11:40 AM revealed that the resident was lying in bed. The resident's Foley catheter drainage bag was lying directly on the floor and was not in a privacy bag. An additional observation of the resident on February 13, 2023, at 8:12 AM revealed that the resident's urinary catheter drainage bag was again lying on the floor and not in a privacy bag. Interview with the Director of Nursing on February 14, 2023, at approximately 10:00 AM revealed that urinary catheter drainage bags should not be lying on the floor and uncovered and confirmed that the facility failed to provide services to prevent complications related to the use of indwelling urinary catheters 28 Pa. Code 211.10(a)(d) Resident care policies. 28 Pa. Code 211.12(a)(c)(d)(1)(3)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on review of clinical records and select facility policies and staff interviews, it was determined that the facility to timely monitor resident weights and meal consumption to ensure prompt and adequate implement nutritional support to prevent progressive weight loss for one resident out of two sampled (Resident 94). Findings include: Review of a facility policy entitled Weight Assessment and Intervention that was last reviewed by the facility on February 10, 2023, indicated that resident's weights are monitored for undesirable or unintended weight loss or gain. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian, physician, and POA (power of attorney). Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. The threshold for significant unplanned and undesired weight loss will be based on the following: 1 month - 5% weight loss is significant; greater than 5% is severe, 3 months - 7.5% weight loss is significant; greater than 7.5% is severe, and in 6 months - 10% weight loss is significant; and greater than 10% is severe. The facility's Meal Intake Monitoring Policy and Procedure that was last reviewed by the facility on February 10, 2023, indicated that it is the policy of the facility to monitor each resident's meal intake daily. Identification of changes in meal intake and subsequent interventions as needed will be an interdisciplinary approach involving all team members. The NA (nurse aide) documents meal consumed at each meal, on each resident in Point Click Care (electronic health record) and the nurse assesses each resident triggered by Point Click Care for decreased meal intake or signs of nutrition related risk. Any resident that is identified by nursing as being at risk for compromised nutritional status is referred to the dietitian and is followed up by the dietitian immediately. Any resident that is identified as at risk for compromised nutritional status by nursing is brought to the attention of the facility to be discussed with the interdisciplinary team. Any resident identified as at risk for compromised nutritional status will be followed by the dietitian and interdisciplinary team until the risk is eliminated. A review of Resident 94's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses to have included major depressive disorder, heart failure [is a progressive heart disease that affects the pumping action of the heart muscles and causes fatigue, shortness of breath], and muscle wasting [refers to the loss of muscle and tissue]. The resident's admission Nutrition Risk Assessment: Full/Discharge completed by the registered dietitian (RD) on September 2, 2022, at 11:07 AM, revealed that the resident's weight on admission was 172.4 pounds. The resident was receiving a NAS (no added salt diet) regular texture with thin liquids diet. The resident's estimated nutritional requirements were noted as at 2,000 - 2,300 calories per day, 78 gm protein per day, and 2,000 milliliters of fluid per day. The RD noted that the resident's nutritional goals were weight stability, intakes greater than 50%, and diet tolerance. The resident's initial intakes were 0-25% and that the resident's RP (responsible party) had not seen a change in the resident's weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 94's care plan dated September 2, 2022, identified that the resident may be nutritionally at risk related to peptic ulcer, CHF, depressive disorder, HTN, and hyperlipidemia with the goals to consume greater than 50% at all meals, to maintain current weight with no significant weight changes through next review, and to tolerate diet. Planned interventions were to consult the dietitian prn (as needed), encourage for greater than 50% meal consumption, monitor for changes in amount of food consumption, record and monitor intakes, and to record and monitor weights. The resident's admission weight on September 1, 2022, at 4:11 PM, was 172.4 pounds. On September 2, 2022, at 4:59 PM, the resident's weight had decreased to 167.1 pounds, a 5.3 lbs weight loss or 3% loss of body weight in 24-hours. There was no documented evidence a re-weight was obtained to confirm the significant weight loss in 24-hours and that the RD was notified of the significant weight change to re-evaluate the resident's nutritional status for further intervention to deter further significant weight loss. There was no evidence that the resident's attending physician and RP were notified of the weight loss. A Dietary Progress Note - Significant Weight Change dated October 18, 2022, at 4:52 PM, revealed that the resident's most current weight on October 1, 2022, was 161 lbs and the resident was trending for a non-significant weight loss of 3.7% in one-month (weight change since admission was 6.6% or a significant weight loss per facility policy). The RD recommended to add shakes to the resident's breakfasts and dinners to deter weight loss and stabilize weight. The resident's nutrional goal was to weight stability, intakes greater than 50%, diet tolerance and no signs or symptoms of hyper/hypoglycemia. On November 10, 2022, at 11:15 AM, the resident's weight was 160.8 lbs and December 8, 2022, 148.6 lbs, a a significant weight loss of 12.2-pounds/7.5% of body with in less than 1 month. The resident's survey documentation report for November 2022 revealed that staff failed to record the resident's meal consumption at 21 meals out of 90 meals served. Staff noted that the resident consumed 0 or 0-25% at meals on 10 occassions out of 90 meals served and consumed 26-50% of meals on 20 occassions out of 90 meals served. Staff noted that meal intake was not applicable twice and unavailable at meals once A significant weight change progress dated December 9, 2022, at 11:03 AM, revealed that the resident's current weight was 148.6-pounds and that her weight one-month ago was 160.8-pounds. In the weight summary, the RD noted that the resident's weight trended for a significant weight loss of 7.6% in one-month and that the weight loss was undesirable and unplanned. The RD recommended increasing the shakes to three times per day while a re-weight was pending and that additional interventions would be assessed when the re-weight was obtained. Dietary progress notes dated December 16, 2022, at 11:03 AM, revealed that a re-weight request was still pending. The RD added weekly weights for close monitoring while pending re-weight. Review of Resident 94's weight record revealed that the resident's next weight was not obtained until December 22, 2023, at 8:36 AM (2-weeks later), and revealed a weight of 146.5 lbs, a loss of 2.1 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's survey documentation report for December 2022 revealed that staff failed to record the resident's meal intake on 30 occassions out of 93 meals served. The facility failed to timely monitor the resident's weight and promptly obtain re-weights to verify signifcant weight loss. The facility further failed to consistently and accurately monitor the resident's meal intake to accurately plan attending physician and representative were notified of the resident's significant weight losses, which was confirmed during interview with the Nursing Home Administrator on February 15, 2023, at 10:15 AM. 28 Pa Code 211.6(c)(d) Dietary services. 28 Pa Code 211.12 (a)(c)(d)(3)(5) Nursing services. 28 Pa Code 211.10 (a)(c)(d) Resident care policies.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on observations, clinical record and select policy review, and staff interview it was determined that the facility failed to provide care and services designed to prevent potential complications with enteral tube feedings for one resident receiving an enteral feeding out of 29 residents sampled (Resident 24). Findings include: Review of a facility policy entitled Tube Feed last reviewed by the facility February 2023, indicated that the facility will maintain an optimal level of nutrition and hydration for all residents when oral intake is inadequate or not possible and to provide an alternate route for administrating medications when the resident is unable to swallow. Further it is indicated the facility is to cleanse the peg tube site with soap and water and turn tube 360 degrees to prevent adherence to the skin. Review of Resident 24's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included dysphagia (difficulty swallowing), anoxic brain damage (damage caused by lack of oxygen to the brain), and quadriplegia (paralysis of the arms and legs). Resident 24 required a PEG tube [Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube (PEG tube) is passed into the patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate [for example, because of dysphagia] for enteral feeding [enteral nutrition generally refers to any method of feeding that uses the gastrointestinal (GI) tract to deliver part or all of a person's caloric requirements]. Review of Resident 24's plan of care, initiated on November 21, 2019, revealed the focus related to the need for tube feeding to maintain nutrition status due to chewing and swallowing difficulties. Interventions planned were to administer the tube feeding formula, hydration, and flushes as order. The care plan failed to identify the type and size of the PEG tube the resident required or how and when to cleanse and provide care to the peg tube site The resident had a physician order, dated January 25, 2022, for Isosource HN 1.2 Cal at 82 ml (milliliters) an hour for 18 hours a day off at 10:00 AM on at 4:00 PM (a liquid high calorie entral feeding formula). The order also noted that the resident is to receive 250 mL water flush every six hours for hydration, and 50 mL water flush pre and post medications. The resident's physician orders failed to specify the type and size of PEG tube the resident required. A review of the resident's clinical record revealed no documentation that the resident was receiving cleaning and care to her PEG tube site as outlined in the facility policy. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of the resident's tube feeding and pump on February 13, 2023, at approximately 8:00 AM revealed that the resident was not in her room receiving the tube feeding due to her PEG tube becoming dislodged from her stomach. The PEG tube was observed attached to the tubing, which connected to the bag of tube feeding formula and was hanging over the pump. The PEG tube balloon was still inflated and intact at the bottom of the PEG tube and appeared brown in color. The tube feed solution was had dripped on the pump, pole, stand, and floor. An observation of the resident on February 14, 2023, at 8:15 AM revealed the resident lying in bed. The tube feeding and the pump was running and delivery enteral feedings to the resident. The tube feeing was leaking out of the tubing at the site the tubing connected to the bag of formula. There was a large amount of enteral feeding formula on the privacy curtains and accumulated on the floor. As a result of the feeding formula leakage nursing staff was unable to determine the accurate volume of feeding formula the resident had received. An observation of the resident on February 15, 2023, at approximately 9:40 AM revealed the leaking tube feeding solution was still covering the privacy curtain. Dried tube feed solution was observed on the pump, stand, pole, and floor. Interview with the Nursing Home Administrator on February 15, 2023, at approximately 3:30 PM, confirmed that the facility failed to provide care and services designed to prevent potential complications associated with tube feedings and that the facility failed to ensure that tube feeding equipment was maintained in a sanitary manner. 28 Pa. Code 211.11 (d) Resident care plan 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing services. 28 Pa. Code 211.10(a)(d) Resident care policies

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of clinical records and select facility policy, and staff and resident interviews it was determined that the facility failed to ensure that physician ordered intravenous antibiotics were administered and intravenous access sites were assessed as consistent with professional standards of quality for three out of 29 residents sampled (Resident's 58, CR6 and 113). Findings include: Review of a facility policy entitled Infusion Therapy Responsibilities and Scope of Practice that was reviewed by the facility on February 10, 2023, indicated that nursing responsibilities include to administer medications within specified times, starting treatments within a reasonable time after the order is written, and administering medications in a safe, responsible manner and performing ongoing assessments of resident's during infusion therapy. Nursing should perform functions and procedures that are consistent with current standards of care, facility policies and procedures, and that are within the scope of state nurse practice act. Additionally, nursing is responsible for maintaining adequate documentation. Review of Resident 58's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to have included bacterial meningitis [is an infection of the membranes (meninges) that protect the spinal cord and brain that can be caused by a bacterial, fungal or viral infection], dementia without behavioral disturbance, dysphagia (difficulty swallowing, and history of left sided colitis [is an inflammation of the inner lining of the colon (large intestine)]with unspecified complications. A physician order dated January 16, 2023, at 7:51 AM, was noted for a central tunneled [(also called a tunneled central venous catheter) is a catheter (thin tube) that is placed under the skin in a vein, allowing long-term access to the vein that is most commonly placed in the neck (internal jugular) but may also be placed in the groin (femoral), liver (transhepatic), chest (subclavian) or back (trans-lumbar)]/non-tunneled [is inserted directly into the vein, without passing under the skin and only have entry sites, not exit sites] IV heparin lock flush, use 1 applicator intravenously every shift for maintenance flush after each use, (after 0. 9% sodium chloride flush) Heparin (5ml) (No heparin needed for closed tip/valved catheter). Physician orders dated January 17, 2023, at 10:16 AM, were noted for cefazolin [is an antibiotic that is used to treat bacterial infections, including severe or life-threatening forms] sodium intravenous solution reconstituted with 2 grams given intravenously every 12-hours for cerebral spinal fluid infection until January 21, 2023, at 11:59 PM. Further review of physician's orders dated January 24, 2023, at 12:00 PM, revealed an order remove midline. Review of Resident 58's Treatment Administration Record (TAR) for January 2023 and clinical record failed to reveal evidence of the initial assessment and care of the resident's access site. The resident's care plan did not include the care of the IV ATB infusion site. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident CR6's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses to have included cerebral infarction [is a medical condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it] with hemiparesis [weakness of one entire side of the body] and hemiplegia [paralysis that affects only one side of the body] to the left non-dominant side, staphylococcus aureus infection [is a gram-positive bacteria that cause a wide variety of clinical diseases with treatments being challenging to treat due to the emergence of multi-drug resistant strains such as MRSA (Methicillin-Resistant Staphylococcus aureus)], dysphagia (difficulty swallowing), and speech and language deficits following stroke. A physician orders dated January 18, 2023, at 12:43 PM, was noted to assess PICC /Midline Catheter and document the total catheter length in cm (centimeters) and document the external length in cm every shift for IV maintenance and document any changes in external length, any signs or symptoms of any infusion-related complications, if the treatment dressing was adherent and intact, if the catheter and tubing were properly secured, and if the needless connectors were present and secure. Physician orders dated January 18, 2023, at 2:37 PM, were noted for for cefazolin [is an antibiotic that is used to treat bacterial infections, including severe or life-threatening forms] sodium intravenous solution reconstituted with 2 grams given intravenously three times a day for diagnosis of staph aureus for nineteen days. Review of Resident CR6's care plan dated on January 18, 2023, indicated that the resident received IV [(Intravenous therapy) is a medical technique that administers fluids, medications, and nutrients directly into a person's vein] via PICC line [(Percutaneously Inserted Central Catheter) is a medical device that is placed into a vein to allow access to the bloodstream. A type of vascular access device that allows fluids and medications to be given to a patient] to the right upper extremity for IV ATB (antibiotics) with a noted intervention to administer the medication as per the physician's orders. The resident's plan of care identified that the MRSA infection site was bacteremia with noted interventions to medicate per MD order and observe for side effects of medication. Resident CR6's Medication Administration Record (MAR) for January 2023 revealed that the physician prescribed ATB was not administered on the following dates: January 18, 2023, at 10:00 PM, January 19, 2023, at 10:00 PM, January 21, 2023, at 2:00 PM, January 22, 2023, at 2:00 PM, January 22, 2022, at 10:00 PM, January 23, 2023, at 6:00 AM, January 25, 2023, at 10:00 PM, January 26, 2023, at 10:00 PM, January 27, 2023, at 2:00 PM, and January 27, 2023, at 10:00 PM. The facility failed to administer eleven (11) doses of IV cefazolin that was prescribed by the attending physician. Further review of the January 2023 MAR and TAR (treatment administration record) revealed no documented evidence that staff assessed Resident CR6's PICC line site as indicated by the physician's orders. Interview with the Director of Nursing (DON) on February 15, 2023, at 2:15 PM, confirmed that the facility failed to assess IV access sites, facility failed to administer 11 doses of IV ATB therapy prescribed for CR6, and failed notify the attending physician of the missed doses. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed that Resident 113 was admitted to the facility on [DATE], with diagnoses to include chronic osteomyelitis and intercranial abscess. Physician orders dated January 20, 2023, were noted for Cefepimine HCL (an antibiotic medication) IV (intravenous) solution 1 gm/50 ml, 1 gm every 6 hours until February 17, 2023. A review of a MAR (medication administration record) dated January 2023 revealed no documented evidence that the IV antibiotics were administered to the resident as ordered on the following dates: -January 20, 2023, 6 P.M. -January 21, 2023, 12 A.M. -January 22, 2023, 12 P.M. -January 23, 2023, 6 A.M. -January 28, 2023, 12 P.M. -January 29, 2023, 6 A.M and 12 P.M. -January 30, 2023, 6 P.M. There was no documented evidence at the time of the survey ending February 15, 2023, that Resident 113 received the IV antibiotic as per the Physicians orders, which was confirmed during interview with the DON on February 14, 2023 at 1 PM, the DON. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.12(a)(c)(d)(1)(3)(5) Nursing Services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 41520 Based on observation and staff interview, it was determined that the facility failed to maintain respiratory and oxygen equipment in a manner to promote optimal functioning for three residents out of 29 sampled residents (Resident 20, 25, and 86). Findings include: An observation on February 12, 2023, at approximately 8:20 AM, revealed that Resident 20 was seated in a wheelchair receiving oxygen therapy. The water canister to provide humidification to the oxygen and oxygen tubing were not dated when put into use An observation on February 12, 2023, at approximately 8:25 AM revealed that Resident 25 was lying in bed sleeping receiving oxygen therapy. The water canister to provide humidification to the oxygen and oxygen tubing were not dated when put into use. An observation on February 13, 2023, at approximately 8:00 AM, revealed Resident 20 and Resident 25 receiving oxygen therapy. The water canisters and oxygen tubing were not dated when put into use. An observation on February 12, 2023, at approximately 12:00 PM revealed Resident 86 seated in a chair at her bedside receiving oxygen therapy. The water canister to provide humidification to the oxygen and oxygen tubing were not dated when put into use. Interview with the Director of Nursing on February 14, 2023, at approximately 2:30 PM, revealed the oxygen tubing should be changed every seven days and the tubing and water canister should be dated and confirmed the facility failed to maintain the residents' oxygen equipment. 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing Services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41520 Based on a review of select facility policy and clinical records and staff interview, it was determined that the facility failed to administer pain medication as prescribed by the physician and attempt non-pharmacological interventions to alleviate pain prior to the administration of pain medication prescribed on an as needed basis for one of 29 residents reviewed (Resident 8). Findings include: A review of the facility policy entitled Pain- Clinical Protocol indicates. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. Additionally, it is noted staff will use a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. Using the numeric pain scale 1-3 mild, 4-7 moderate, 7-10 severe or residents verbal description of pain tolerable /intolerable or severe. Treatment and Management of pain includes that the physician will order appropriate non-pharmacologic and medication interventions to address the individuals pain. Review of Resident 8's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses to include aftercare following joint replacement and depression. Review of a quarterly MDS assessment dated [DATE], revealed that the resident received scheduled pain medication regimen and received PRN pain medications. The MDS noted that the resident did not receive non-medication intervention for pain in the last 5 days. The resident stated that he frequently experienced pain or hurting in the last 5 days and rated this pain on a scale of 0-10 (zero being no pain and ten as the worst pain you can imagine), as a 5 according to the MDS. Review of Resident 8's care plan, dated as revised August 5, 2022, revealed a focus of a potential for pain related to left hip replacement, osteoarthritis of both hands, peptic ulcer disease and osteoporosis. Planned interventions were to administer analgesia as per orders. Over a half hour before treatments of care, evaluate the effectiveness of pain interventions. Review for compliance alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition, identify and record previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effects and impact on function., monitor and document for probable cause of each pain episode. Remove/limit causes where possible and notify physician if interventions are unsuccessful or if current complaint is a significant change for residents past experience of pain. A physician order dated August 8, 2022, was noted for Norco (a narcotic opioid pain medication used to help relieve moderate to severe pain) 7.5 milligram (mg)-325 mg as needed every six hours, give 1 tablet by mouth every 6 hours as needed for moderate and a physician order dated August 8, 2022, for Norco 7.5-325 mg, give 2 tablets by mouth as needed for severe pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 8's January 2023 Medication Administration Record that staff administered Norco 7.5-325 mg as needed every six hours, 2 tablets, for a pain level 5 on January 2, 2023, January 3, 2023, January 4, 2023, January 6, 2023, January 8, 2023. Additionally, the resident was provided 2 tablets on January 11, 2023, January 15, 2023, for a level 7, January 21, 2023 for a level 2, January 23, 2023 for a level 5, January 24 for a level 2, January 27 for a level 5, January 29, 2023 for level 0, January 30, 2023 for level 7 and January 31, 2023 for level 5, all of which are considered moderate pain, which was not consistent with the physician order and facility pain scale . Review of Resident 8's February 2023 Medication Administration Record revealed that the resident was provided Norco 7.5-325 mg as needed every 6 hours, 1 tablet, for a pain level 8 on February 12, 2022 which was ordered for moderate pain (4-7). Resident 8's February 2023 Medication Administration Record Revealed the resident was provided Norco 7.5-325 mg as needed every 6 hours, 2 tablets for a pain level 6 on February 1, 2022, level 7 on February 3, 2023, level 2 on February 6, level 7 on February 9, 2023, and level 0 on February 10, 2023, ordered for severe pain (8-10). Further review of Resident 8's clinical record failed to reveal non-pharmacological interventions attempted prior to the administration of the prn pain medication. Interview with the Nursing Home Administrator on February 15, 2023 at approximately 3:00 PM confirmed facility failed to provide effective pain management and administer pain medication as per facility policy or offer non-pharmacological interventions. 28 Pa. Code 211.2(a) Physician Services 28 Pa. Code 211.5(f)(g) Clinical records 28 Pa. Code 211.12(a)(c)(d)(1)(3)(5) Nursing Services

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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. 41581 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that one of 29 sampled residents was seen timely by a physician (Resident 51). Findings include: A review of the clinical record of Resident 51 revealed admission to the facility December 17, 2022, with diagnoses which included hemiplegia (paralysis on one side of the body) following cerebral infarction (stroke). The resident's payor source at the time of admission was Medicare. A review of the resident's clinical record revealed Employee 9, certified registered nurse practitioner (CRNP) visited the resident on December 19, 2022, December 29, 2022, January 26, 2023, and February 6, 2023. There was no documented evidence the resident's attending physician visited the resident every 30 days for the first 90 days after admission. Interview with the Director of Nursing on February 15, 2023, at approximately 2:30 PM confirmed that the physician did not visit Resident 51 as required. Refer F840 28 Pa. Code 201.18 (e)(3) Management 28 Pa. Code 211.2 (a)(d)(2) Physician services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41581 Based on a review of clinical records, the minutes from Resident Council Meetings, grievances and nursing staffing hours, observations and staff and resident interviews it was determined that the facility failed to provide and/or efficiently deploy sufficient nursing staff to consistently provide timely quality of care, services, and supervision necessary to maintain the physical and mental well-being of the residents in the facility including Residents 38, 116, 33, 7, 63, 105, and 111. Findings include: A review of the facility's weekly staffing levels revealed that on the following dates the facility failed to provide minimum nurse staffing of 2.7 hours of general nursing care to each resident: January 14, 2023, -2.35 direct care nursing hours per resident January 15, 2023, -2.61 direct care nursing hours per resident January 28, 2023, -2.35 direct care nursing hours per resident January 29, 2023, -2.61 direct care nursing hours per resident February 11, 2023, -2.35 direct care nursing hours per resident February 12, 2023, -2.61 direct care nursing hours per resident February 14, 2023, -2.61 direct care nursing hours per resident On the above noted dates, the facility failed to provide 2.7 hours of direct nursing care daily. During the week of February 8, 2023, through February 14, 2023, the facility provided an average of 2.67 hours of general nursing care per resident per day during the 7 day period. The facility failed to meet the minimum state regulatory requirement for nursing time on these days. A review of the census for the C2 nursing unit during the time of the survey revealed the unit had 53 residents residing on this unit. Observation of the C2 nursing unit on February 12, 2023, at approximately 8:15 AM revealed two LPNs (license practical nurse) passing medications to the residents. There were four nurse aides, two on each hall of the unit, passing meal trays and trying to assist residents with their meals. Multiple call bells were ringing on the nursing unit and going unanswered. There were multiple residents in the dining room eating their breakfast unsupervised as staff were performing other duties at this time leaving the dining room unsupervised. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the census for the B2 nursing unit during the time of the survey revealed the unit had 39 residents residing on this unit Interview with Resident 63 on February 13, 2023, at 9:38 AM revealed that the resident stated that do not check her every two hours for toileting needs according to her care plan. The resident stated that she is incontinent because staff do not respond timely to her toileting needs when she activates the call bell requesting staff assistance with toileting. The resident stated when she feels to urge to urinate, she rings the call bell, and then waits anywhere from 30 minutes to over an hour. The resident stated so of course, I'm incontinent. I can't hold it that long and I need staff assistance with toileting. An interview with Employee 3, Agency LPN, on February 14, 2023, at approximately 4:40 PM revealed that this nurse stated that herself, another LPN, and one nurse aide were working on the unit at the time. Employee 3 stated she doesn't know how all the work will get done because they have to pass medications and perform their duties while trying to help the one nurse aide on the floor caring for the residents. She stated there are multiple residents on the unit that need the assistance of two nursing staff to provide their care. Review of Resident 105's care plan, initiated on February 25, 2022, and revised on September 12, 2022, identified that the resident had potential to exhibit physical aggression and sexual attention towards others with a goal that Resident 105 would not have any physical aggression or sexual attention towards others. Planned interventions were to avoid crowded, noisy groups due to exacerbation of anxiety and aggressiveness, encourage appropriate behaviors with others and educate on appropriate behaviors with others, and every 15 - checks as per protocol. The resident's care plan also noted behavioral problems characterized by inappropriate verbal sexual behavior, making inappropriate remarks towards others. The planned intervention were for staff to conduct every 15-minute checks to prevent wandering in others' rooms, especially at night. During interview with Employee 22, a nurse aide, on February 13, 2023, at 10:30 AM, related that staff are to record their observations when performing every 15-minute checks of Resident 105, but , revealed staff wasn't always able to complete the checks as planned, especially on the weekends, due to limited staff working on the D-Unit. The facility failed ensure adequate staffing to conduct Resident 105's planned every 15-minute checks to manage unsafe behaviors. Review of Resident 111's care plan, initiated February 25, 2022, and revised September 12, 2022, identified that the resident had potential to wander/elope as evidence by previous elopement history from prior facility window, impaired judgement/decision making, poor safety awareness, exit seeking, and behavioral disturbances/non-compliance. Planned interventions were that all staff be aware of the resident's tendency to wander, apply code alert bracelet and check tag alert every shift for placement at beginning or end of shift and check tag alert transmitter testing every month, and 1:1 until further notice due to a recent elopement event. A nursing progress note by Employee 26, a LPN, on January 7, 2023, at 6:41 PM, revealed that every 15 - minute checks were to be conducted that evening due to no staff available to provide for 1:1 and that the supervisor was made aware and stated that 1:1 with Resident 111 would continue when staff becomes available. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Employee 22 on February 13, 2023, at 10:30 AM, revealed that 1:1 supervision was not consistently provided Resident 111, but staff attempted to have Resident 111 in line of sight. Employee 22 stated that due to limited nurse staffing on the D-unit staff are not available to provide 1:1 supervision of Resident 111. At the time of the survey ending February 15, 2023, at 3:00 PM, the facility failed to consistently provide 1:1 Resident 111 as planned due to insufficient staffing, which was confirmed during interview with the NHA on February 15, 2023, at 3:00 PM. A review of the minutes from Resident Council Meetings dated September 29, 2022, revealed that the residents attending voiced complaints that nursing staff are not answering their call bells in a timely manner on all shifts of nursing duty. A review of grievances lodged from the September 29, 2022, Resident Council meeting revealed that residents had concerns with call bells not being answered timely and not receiving showers. According to the grievance the facility would provide in-services and education to staff about answering call bells and providing showers. A review of the minutes from the Residents Council meeting dated October 20, 2022, revealed that the residents in attendance remained dissatisfied with the untimeliness of staff's response to their call bells and this problem remained an unresolved issue from last month's meeting. The facility noted that the it is still being worked on, with evidence as to how the facility was working on this issue to satisfactorily resolve the residents' continued complaints regarding untimely staff response to call bells and meeting their needs for assistance in a timely a manner. The facility did not complete a grievance in response to the residents' complaints voiced during the October 20, 2022, Resident Council meeting. A review of the minutes from the Resident Council meeting dated November 15, 2022, revealed that the residents continued to have concerns with the untimeliness of nursing staff's response to their call bells. A grievance from the November 15, 2022, Resident Council meeting noted that the residents complained that their call bells are not being answered timely and the facility's response was to initiate call bell audits. A review of the minutes from the Resident Council meeting dated December 27, 2022, revealed that the residents in attendance stated that they are unsatisfied with their care and call bells are not being answered timely. The grievance from the December 27, 2022, Resident Council meeting revealed that the residents complaint that call bells are still not being answered in a timely manner. The facility's response was to continue call bell audits. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The minutes from the Resident Council meeting dated January 26, 2023, again indicated that residents were not satisfied with their care in the facility and nursing staff were not answering their call bells timely. The residents complained that there was not enough staff on various shifts of nursing duty during the week and call bells are not being answered timely on the second and third shifts of nursing duty. A review of grievances from the January 26, 2023, Resident Council meeting revealed that the residents complained that their call bells are still a problem and staff are not answering them timely. The facility noted that education was provided to staff and they will continue call bell audits. The grievance also noted that the residents were concerned that there was not enough staff during the week to provide their care, to which the facility responded that they would monitor the nursing hours to ensure their meeting the requirement each day. During a group interview with residents, Resident 38, 116, 33, and 7 on February 14, 2023, at 10:30 AM, revealed that all residents stated that nursing staff do not answer their call bells in a timely manner and provide timely care when requested. The residents stated that the problem has continued for months and remains unresolved by the facility. The residents stated that the facility is short staffed and call bells are not being answered timely, and the is worse on the weekends and on second shift of nursing duty. The residents stated that, at times, there is only one nurse aide to work an entire resident unit and they cannot meet all the residents needs because there's just too much work for one person. The residents stated these same concerns are ongoing issues that have been brought up during Resident Council meeting for months. The residents also stated that at times that staff won't help and provide assistance to select residents because the aides have lists of their residents for which they are responsible or they are too busy providing care for other residents. The residents stated that they have to wait long periods of time to get assistance from their assigned nurse aide. The residents also stated they believe sometimes food is cold because there is not enough nursing staff to pass the meal trays timely once dietary staff deliver them to the resident unit. The residents stated they believe their care would be better if the facility had more nursing staff to meet the residents' needs timely. Interviews with Residents 7 and Resident 116 during a group meeting conducted on February 14, 2023, at 10:26 AM, revealed that residents complained that their meals were not served hot and they receive foods they dislike on their meal trays. The residents also reported that are only able to eat meals in the facility's main dining room at lunch, Mondays through Fridays due to the lack of staff to provide necessary assistance with transporting. Interviews with nursing staff members, who did not wish to be identified due to fear of retaliation by the facility, during the survey ending February 15, 2023, revealed that the facility is often shorthanded of nursing staff. The nursing staff members interviewed stated that they often work at critically low staffing levels, as confirmed by the direct care nursing hours per resident per day noted above. The facility failed to provide sufficient nursing staff to provide the necessary services to meet the clinical, safety and care needs of the residents residing in the facility. Refer F689, F690, F744 28 Pa. Code 211.12(a)(c)(d)(1)(4)(5)(g)(i) Nursing services 28 Pa. Code 201.18(e)(1)(2)(3)(6) Management

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41520 Based on a review of clinical records and select reports, observations, and staff interviews, it was determined that the facility failed to develop and implement an individualized person-centered plan to address resident's dementia-related behavioral symptoms and provide the necessary care to manage dementia related behaviors for four residents out of 29 sampled residents (Residents 2, 74, 105, and 111). Findings include: A review of the clinical record revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety (a decline affecting memory, normal thinking, communicating which make it difficult to perform normal activities of daily living such as dressing, eating and bathing). The resident had a current physician order Haloperidol (an antipsychotic) 0.5 milligrams (mg) give 1 tablet by mouth one time a day for dementia with behaviors initially dated August 19, 2022. A review of the resident's clinical record revealed documentation from August 2022 through the time of the survey ending February 12, 2023, that the resident was receiving an antipsychotic medication (Haloperidol) for behaviors related to dementia. However, there was no indication of the specific behavior the resident displayed requiring treatment with the antipsychotic drug. The resident's current care plan, in effect at the time of the survey ending February 15, 2023, did not identify the resident's dementia diagnosis, the resident's specific behaviors the resident exhibits due to her dementia diagnosis and specific interventions to address these behaviors The facility failed to develop and implement an individualized person-centered plan to address, modify and manage this resident's dementia-related behaviors. The resident's care plan for behavioral symptoms failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage the resident's dementia-related behavioral symptoms. Interview with the Director of Nursing on February 15, 2022 at approximately 3:00 PM, confirmed that the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to address dementia with behaviors. Review of Resident 74's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to have included dementia without behaviors disturbance, anxiety, unsteady on feet, muscle weakness, lack of coordination, and dysphagia (difficulty swallowing). A review of Resident 74's 5-Day Minimum Data Set assessment dated [DATE], revealed that the resident had severe cognitive impairment with a BIMS score of 7. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 74' s care plan, dated August 26, 2022, and revised on September 14, 2022, identified that the resident had the potential to wander with interventions that included for staff to be aware of the resident's tendency to wander, attempt to redirect wandering behaviors, and observe the resident's whereabouts throughout the day. Aggressive and threatening behaviors and wandering were documented in Resident 74's clinical record on October 17, 2022, at 4:47 AM, on October 28, 2022, at 4:26 AM, and on November 7, 2022, at 2:34 AM. An incident report dated November 8, 2022, at 6:57 AM, revealed that while in their room Resident 74 struck his roommate, Resident 67, in the chest and then Resident 67 pushed him {Resident 74} away causing him to lose his balance and fall landing on his right side and sustaining bruising to his right leg and chest. On November 9, 2022, Resident 74 was placed on every 15-minute checks, which were then discontinued on November 14, 2022. According to the clinical record, the resident continued to display increasing behaviors of aggressiveness with staff and other resident, restlessness, and paranoid behavior through survey ending February 15, 2023. Observations during survey that began on February 12, 2023, and ended on February 15, 2023, revealed that Resident 74 was observed wandering about the unit and displaying intrusive behaviors with other residents. There was no documented evidence that the facility had developed and implemented individualized interventions designed to address the resident's dementia related behavioral symptoms to promote the resident's psychosocial well-being. Resident 67's care plan in effect at the time of the survey of February 15, 2023, did not identify the specific dementia related behaviors the resident exhibits and individualized person-centered interventions to address each of these behaviors. Interview with the Director of Nursing (DON) on February 15, 2023, at 2:30 PM, confirmed that the facility failed to fully develop and implement a dementia-care plan that included specific interventions to manage Resident 74's behaviors. Review of Resident 105's clinical record revealed that he was admitted to the facility on [DATE], with diagnoses to have included Alzheimer's dementia, stroke, and major depressive disorder. A review of Resident 105's annual Minimum Data Set Assessment revealed that the resident had severe cognitive impairment. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's care plan initiated February 12, 2022, and revised on September 29, 2022, indicated that the resident had the potential to exhibit distressed mood by behavioral symptoms as exhibited by hoarding silverware (butter knife wrapped in napkin hidden in room), tearfulness, flat affect related to diagnoses of depression and dementia. Noted interventions included to reassure the resident of his safety and of purpose to decrease potential of harm due to hoarding silverware, observe for changes in mood such as (i.e. increased hoarding, tearfulness, flat affect etc.) and overall functioning and document. The resident's care plan dated February 25, 2022, and revised on September 12, 2022, identified that the resident had potential to exhibit physical aggression and sexual attention towards others with a noted goal that Resident 105 would not have any physical aggression or sexual attention towards others. Planned interventions were to avoid crowded, noisy groups due to exacerbation of anxiety and aggressiveness, encourage appropriate behaviors with others and educate on appropriate behaviors with others, and every 15 - checks as per protocol. The care plan also noted that the resident had inappropriate verbal sexual behavior related to the resident making inappropriate remarks towards others and a planned intervention for every 15-minute checks to prevent wandering in other's rooms, especially at night. Review of the resident's clinical record documentation from September 2022, through survey ending February 15, 2023, revealed that the resident had several documented episodes of inappropriate sexual statements to staff and other residents and episodes of aggression. Nursing progress notes by Employee 23, a LPN, dated February 9, 2023, at 1:31 PM, revealed that the resident became very agitated post lunch, grabbed at the table and began making growling noises at other residents. Employee 23 noted that the resident showed his fists at another resident and when attempted to intervene he started swinging his fists at Employee 23. Employee 9, a contracted CRNP, dated February 10, 2023, noted that nursing reported increased behaviors, striking out at other residents and staff, and urinating everywhere and anywhere. Employee 9 noted that staff were to continue every 15-minute checks. During observation of D-Unit on February 12, 2023, at 8:00 AM, Resident 105 was observed seated at a table in the resident dining room with several other residents waiting for their breakfasts. There was no staff observed in the dining room area to provide supervision. At that time other residents were yelling out in the dining room and Resident 105 was banging his fists on the table his table and yelling. Resident 105's care plan included the planned intervention for the resident to avoid crowded, noisy groups due to exacerbation of anxiety and aggressiveness and the resident's care plan was not implemented at this time. Observation made on February 12, 2023, at 10:15 AM, revealed that Resident 105 was seated in the activity room with multiple other residents with music playing. The resident's care plan noted that the resident should avoid crowded noisy groups. Interview with the Director of Nursing (DON) on February 15, 2023, at 2:30 PM, confirmed that the facility failed to implement planned interventions to manage Resident 105's dementia related behavioral symptoms. Review of Resident 111's clinical record revealed that he was admitted to the facility on [DATE], with diagnoses to have included dementia without behavioral disturbance. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 111's a quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was severely cognitively impaired. The resident's care plan, initiated February 25, 2022, and revised on September 12, 2022, identified that the resident had potential to wander/elope as evidence by previous elopement history from prior facility window, impaired judgement/decision making, poor safety awareness, exit seeking, and behavioral disturbances/non-compliance. Planned interventions were that that all staff be aware of the resident's tendency to wander, apply code alert bracelet and check tag alert every shift for placement at beginning or end of shift and check tag alert transmitter testing every month, and 1:1 until further notice due to an elopement event. Nursing progress dated during the months of September 2022, October 2022, and November 2022, revealed that the resident had several episodes of exit seeking behaviors, unsafe wandering and that the resident continued to require 1:1 supervision for safety. On November 18, 2022, at 9:47 PM, Resident 111 displayed exit seeking behaviors during beginning of shift, approaching fire exit doors with coat on and a bag with personal belongings, and was redirected to his room, with positive effect. According to the entry the resident remained in his room for remainder of shift with 1:1 supervision. Employee 25, a LPN, documented on November 19, 2022, at 2:39 AM, that when a nurse aide made rounds to check code alert bracelets, Resident 111's wanderguard bracelet was missing. The aide searched his room and found it in his nightstand with the strap cut. Resident 111 stated Oh it was too tight, and that Employee 25 notified the supervisor a new strap was needed due to the resident removing the device and that 1:1 continued. Employee 7 educated Resident 111 to not tamper with his wanderguard. Employee 23 documented on November 19, 2022, at 9:34 AM, that Resident 111's exit seeking behavior continued and that a call was placed to the nursing supervisor for a new replacement band for wanderguard devise and was reapplied to left ankle (7 hours after the resident removed it). Employee 25 noted on November 25, 2022, at 2:22 AM, that resident removed his tag alert on 3 PM -11 PM and broke the device. A replacement was not available and the resident was presently without wanderguard attached to person and 1:1 continues. Nursing supervisor aware. Employee 26, a LPN, noted on January 7, 2023, at 6:41 PM,that every 15 minute checks were to be done, but there was not enough staff to provide 1:1 supervision of 111 and the supervisor made aware and 1:1 would continue when staff becomes available. The resident's 1:1 log dated February 11, 2023, revealed that staff did not observe the resident after 6:00 AM. Observations on February 12, 2023, at 8:02 AM, and at 10:10 AM, revealed no staff providing 1:1 supervision to Resident 111. The resident was observed seated in a dining room crowded with other residents without engagement with purposeful activities or staff engagement. Interview with Employee 22 on February 13, 2023, at 10:30 AM, revealed that 1:1 supervision was not consistently provided due to staffing constraints on the D-unit, but staff attempt to have Resident 111 in sight. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to implement planned interventions including avoiding crowded, noisy groups to decrease exacerbation of anxiety and aggressiveness and to failed to consistently provide 1:1 supervision to assure the resident's safety during wandering behaviors, which was confirmed during interview with the Director of Nursing (DON) on February 15, 2023, at 2:30 PM. 28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services 28 Pa Code 211.11(d)(e) Resident care plan

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41520 Based on observations and staff interview it was determined the facility failed to implement procedures timely and safe disposition of resident medications (the process of returning and/or destroying unused medications) for one of 29 sampled residents (Resident 115). Findings include: Observation on February 14, 2023 at approximately 8:10 AM of the B-2 Unit medication room in the presence of Employee 1, Licensed Practical Nurse (LPN) revealed two large paper bags full of resident medications. The bags contained multiple non-controlled medications that had been dispensed for one resident (Resident CR5). Employee 1, LPN stated that these bags of medications had been dispensed to a resident who has since been discharged and she was unsure why the medications remained in paper bags in the med room. Interview with Employee 21, Registered Nurse Manager at this time revealed that Resident CR5 was discharged on [DATE], and the medications should have been removed and placed in the Registered Nurse Supervisor office for pick up by pharmacy. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.12(a)(c)(d)(1)(3)(5) Nursing Services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records and facility policy and staff interview it was determined that the pharmacist failed to identify duplicate drug therapy and the attending physician failed to act on a pharmacist's identified irregularity in resident drug regimens for three residents out of five sampled (Resident 2, 69 and 78). Findings include: A review of the clinical record revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses to include major depression and unspecified dementia. A review of Resident 2's clinical record revealed that the pharmacist conducted monthly drug regimen reviews on the following dates resulting in the identifications of drug irregularities and recommendations to the physician: August 22, 2022 September 26, 2022 October 23, 2022 November 21, 2022 December 26, 2022 January 23, 2023 However, at the time of the survey ending February 15, 2023, the facility was unable to provide documented evidence that the attending physician had acted upon these identified drug irregularities in Resident 2's drug regimen and pharmacist recommendations A review of the clinical record revealed Resident 78 was admitted to the facility on [DATE], with diagnoses to include anxiety and depression A Consultation Report from the Pharmacist to the physician dated December 26, 2022, revealed that the pharmacist identified the lack of a stop date for a PRN (as needed) Atarax order. At the time of the survey ending February 15, 2023, there was no documented evidence that the resident's attending physician had acted upon this identified drug irregularity. A review of Resident 78's clinical record revealed the pharmacist did conduct a monthly medication review on January 23, 2023, however at the time of the survey ending February 15, 2023, the facility was unable to provide documented evidence that the attending physician had addressed the recommendations identified in Resident 78's medication regimen. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing on February 15, 2023, approximately 3:00 p.m. confirmed the facility was unable to provide documented evidence that the residents' attending physicians acted upon these identified drug irregularities. A review of the clinical record revealed that Resident 67 was admitted to the facility on [DATE], with diagnoses that included generalized anxiety disorder. The resident had a current physician order dated December 21, 2021, for Buspirone HCL 10 (an anti-anxiety drug) mg, by mouth, twice a day for anxiety and Ativan 0.5 mg (an antianxiety drug) by mouth every day for generalized anxiety. There was no documented evidence at the time of the survey ending February 15, 2023, that the Pharmacist identified the irregularity of duplicate anti-anxiety drugs prescribed for treatment of Resident 67's generalized anxiety. During an interview February 14, 2022 at 1 P.M., the DON confirmed that the pharmacy did not identify the duplicate antianxiety medications prescribed for Resident 67. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code 211.2 (a) Physician services

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 26142 Based on a review of clinical records and staff interviews it was determined that the facility failed to ensure that a resident's drug regimen was free of unnecessary antibiotic drugs for one of 29 residents sampled (Resident CR1). Findings included: A review of Resident CR1's clinical record revealed a physician order dated July 2, 2022, to obtain urine culture and sensitivity. A physician's order, dated July 5, 2022, was noted for Levaquin (Levofloxacin) 750 mg daily for urinary tract infection for 5 days. A review of the resident's medication administration record for the month of July 2022, revealed that the resident received two doses of Levaquin. A review of laboratory test results, dated July 4, 2022, revealed the identified organism was resistant to treatment with Levaquin. A new order physician order, dated July 7, 2022, was noted to discontinue Levaquin, and to start Ceftriaxame sodium solution 1 gm, daily for days for a UTI (urinary tract infection). Refer F881 28 Pa. Code 211.12 (a)(c)(1)(3)(5) Nursing services 28 Pa. Code 211.9(a)(1) Pharmacy services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41520 Based on clinical record review and staff interview it was determined that the facility failed to demonstrate adequate monitoring of antipsychotic drug use by one resident out of five sampled (Resident 78). Findings include: Review of Resident 78's was admitted to the facility December 13, 2022, and diagnosis included dementia and depression Review of Resident 78's care plan dated December 14, 2022, indicated that the resident was prescribed antipsychotic medications with planned interventions to administer medications as ordered and monitor and document side effects and effectiveness. A physician order dated December 14, 2022 was noted for 2 mg, one tablet of Risperidone by mouth for anxiety. A physician order was noted December 17, 2022, indicated to give one milligram (mg), one tablet of Risperidone (antipsychotic) by mouth for Major Depressive Disorder. At the time of the survey ending February 15, 2023, the resident continued to receive Risperidone and there was no documented evidence that staff were monitoring Resident 78's use of an antipsychotic medication for side effects and effectiveness. Interview with the Director of Nursing on February 15, 2023, at 3:00 PM confirmed there was no psychoactive drug monitoring in the resident's clinical record. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 41520 Based on observations and staff interviews it was determined that the facility failed to discard multi-dose medications and pharmacy products in accordance with currently accepted professional principles, including necessary use by/discard dates, on two medication carts out of three medication carts reviewed and failed to ensure adherence to expiration/use by dates and failed to safely store medications and pharmaceuticals in one medication storage room and one treatment room of three observed (C-2) Findings include: According to the National Association of Boards of Pharmacy, Uniform Prescription Labeling Requirements, indicate that critical information on prescription labels include the Use by date, which is the Date by which medication should be used, not expiration date of medication or expiration date of prescription. Observation conducted on February 14, 2023, at 8:10 a.m. of the medication cart revealed a multidose vial of Insulin Lispro, belonging to Resident 78 with an initial opened date of December 30, 2022. Interview with Employee 1, Licensed Practical Nurse (LPN), at this time, confirmed the medication was outdated and should been disposed of and not left in the cart for continued resident use. An interview with the Nursing Home Administrator on February 14, 2023, at 10:30 AM confirmed that the multidose insulin vial was expired and should have been removed from the medication cart and not remained available for use. Observations of the C2 nursing unit treatment room on February 12, 2023, at 9:18 AM revealed one bottle of peroxide that expired in January 2023 and three bottles of hand sanitizer that expired in May 2022. Observations of the C2 nursing unit medication room on February 12, 2023, at 9:30 AM revealed one box of lidocaine patches that expired in October 2022, one bottle of hand sanitizer that expired in July 2022, a needle infusion set that expired in December 2020, and a needle free valve set that expired in June 2022. Interview with Employee 10 LPN on February 12, 2023, at 9:39 AM, confirmed the supplies were expired. Observation conducted on February 14, 2023, at 8:40 a.m. of the D unit medication cart revealed an opened flexpen of Insulin Novolog and an opened flexpen of Insulin Glargine-yfgn 100 UNIT/ML Solution, belonging to Resident 125 with no initial open date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation conducted on February 14, 2023, at 8:40 a.m. of the D unit medication cart revealed an opened flexpen of Insulin Glargine-yfgn 100 UNIT/ML Solution, belonging to Resident CR2 with no opened date. Resident CR2 was discharged from the facility on February 6, 2023. Observation on February 14, 2023, at 8:40 a.m. of the D unit medication cart revealed an opened bottle of Visine eye drops, belonging to Resident 84 with no opened date. An interview with the DON (Director of Nursing) on February 14, 2023, at approximately 10:30 AM confirmed the facility failed to remove expired drugs and pharmacy products from the medication room after their expiration date or discard date. An observation of the C2 nursing unit on February 12, 2023, at 9:18 AM revealed the treatment room was unlocked and the door was open. There were no staff present or near the nursing station. Located in the treatment room was a treatment cart. The treatment cart was unlocked and contained wound care supplies, saline flushes, residents' prescription creams and powders, bottles of alcohol and peroxide. The treatment room contained wound supplies and dressings, enemas, skin prep, antibiotic ointment, skin protectant cream, antifungal cream, bottles of alcohol, peroxide, and hand sanitizer. An observation of the C2 nursing unit medication room at approximately 9:30 AM revealed the medication room was unlocked and there were no staff present at the nursing station. The medication room contained multiple over the counter medications, prescribed medications for residents, and insulin syringes. An interview with Employee 10 LPN (license practical nurse) on February 12, 2023, at approximately 9:40 AM revealed the employee stated the medication room is left opened because the key not always working and the staff won't be able to get into the medication room. An observation on February 13, 2023, at 8:06 AM revealed the medication room was left unlocked and the door was opened. There were no staff present in the medication room or near the nursing station. An observation on February 14, 2023, at 8:15 AM revealed both medication room doors were unlocked and left opened. Both nurses were down the halls completing medication pass and no staff were present at the nursing station. Further observations on 9:50 AM revealed Employee 2 NA (nurse aide) entering the medication room since the doors were left opened, storing her personal belongings in the medication room and not closing or locking the door. An interview with the Nursing Home Administrator on February 14, 2023, at approximately 2:30 PM revealed the medication and treatment room doors should be locked at all times and never left open unattended. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observations, review of the facility's menus and corresponding recipes, and resident interviews, it was determined the facility failed to ensure effective management and execution of the facility's food and nutrition department to provide consistent planned meals to meet the nutritional needs and dietary preferences of each resident including Resident 5. Findings included: Observations on June 13, 2023, and a review of the facility's planned cycle menus and staff interviews it was determined that the facility failed follow written planned menus. The facility census at the time of the survey ending June 14, 2023, was 123 residents currently residing in the facility. A review of the current weekly menu beginning on Sunday June 11, 2023, and running through Saturday June 17, 2023, revealed that that a baked omelet, Chicken, broccoli and rice casserole, cake of the day, beef macaroni and cheese and baked cheese omelet was planned on the menu during the week for the breakfast, lunch and dinner meal. A review of associated facility recipes revealed that flour was an ingredient in all of the above noted recipes. Further review of the weekly menu revealed that: cake of the day was planned several times during this week for lunch and dinner meal. A review of associated facility recipes revealed that sugar was an ingredient in the cake recipes. During a tour of the kitchen on June 13, 2023, including the dry storage areas no flour or bulk sugar was observed to be available. During an interview at the time of the observation, the food service manager confirmed that there was no flour or sugar in the kitchen or storage for use in food preparation. The food service manager stated the cook would substitute corn starch for the flour in the recipes, and offered no substitute for the sugar in the recipes. An observation of the lunch meal on June 13, 2023 at 12 PM, revealed that during service, multiple residents were observed to request soft sandwiches, but none were readily available to serve to the residents. A dietary staff member left the lunch tray line service to make sandwiches. Further observation of the lunch meal revealed that the cook had not prepared any gravy to serve over the mechanical chopped chicken according to the recipe and menu. The cook was plating the chopped chicken for the mechanically altered diet and putting the chicken broccoli rice casserole on top of the meat as a substitute for the planned gravy. There were no puree dinner rolls to be served to the mechanically altered diets as per the lunch meal menu. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview at the time of the observation, the food service manager confirmed that soft sandwiches should be available for every lunch and dinner meal as an alternate. In addition, he stated that the cook should have made gravy as noted on the menu and should not have substituted the chicken broccoli rice casserole to flavor/moisten the chopped chicken for the mechanically altered diet. A review of the clinical record revealed that Resident 5 was admitted to the facility on [DATE], with diagnoses to include end stage renal disease on dialysis. The resident had a current physician order dated September 9, 2022, for a regular texture renal diet. An observation of the lunch meal service tray line on June 14, 2023, at 11:50 AM revealed that the resident's meal tray ticket indicated that the resident was to be served a chicken breast, broccoli, rice and a dinner roll. The cook prepared the resident's lunch and placed chicken rice and broccoli casserole and carrots instead of the chicken breast, rice and broccoli on the plate. There was no dinner roll available on the trayline. The food was plated and placed into the cart and sent to the nursing unit for service to the resident. An interview June 13, 2023 at 12:15 P.M., the corporate dietary manager confirmed that Resident 5 did not receive the correct diet as per the physician order. Interview with the Nursing Home Administrator on June 14, 2023, at approximately 2 PM confirmed that residents are to be served food in the form to meet their needs according to the physician order and as noted on their individual meal tray ticket, recipes are to be followed, food prepared as planned on the menu and flour and sugar should be available in the kitchen for meal preparation. Refer F804, F805, F808 and F812 28 Pa. Code 211.6 (a)(b)(c)(d) Dietary Services 28 Pa. Code 201.18 (e)(3) Management

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43944 Based on observation, resident and staff interview, test tray results, and a review of minutes from the facility's food committee meeting, it was determined that the facility failed to provide meals that are served at safe and palatable temperatures. Findings include: Interviews with Residents 7 and Resident 116 during a group meeting conducted on February 14, 2023, at 10:26 AM, revealed that residents complained that their meals were not served hot and they receive foods they dislike on their meal trays. The residents reported that are only able to eat meals in the facility's main dining room at lunch, Mondays through Fridays due to the lack of staff. Resident 7 stated that his meal ticket says no gravy, but he often received gravy on his foods. During an observation in the kitchen of the lunch meal service on February 14, 2023, at 11:55 AM, revealed that the temperatures of the meal items prior to service were as follows: spaghetti was at 178 degrees Fahrenheit, meatballs were at 186 degrees Fahrenheit, cucumber salad was at 34 degrees Fahrenheit, strawberry short cake was at 35 degrees Fahrenheit, and hot water was at 180 degrees Fahrenheit. Observation of D-Unit's lunch meal service on February 14, 2023, at 12:20 PM, revealed that the lunch cart arrived on the nursing unit at 12:18 PM and tray distribution began at that time. The final tray was passed at 12:31 PM. A test tray was completed at 12:32 PM revealing spaghetti with meatballs was at 128.5 degrees Fahrenheit, cucumber salad was at 62.4 degrees Fahrenheit, strawberry short cake was at 74.7 degrees Fahrenheit, and hot water for tea was at 125.8 degrees (Acceptable temperature for hot foods should be 135 F degrees or greater and cold food should 41 F degrees or less) The temperatures were confirmed by the Employee 27, an agency nurse aide. The hot food was luke warm and not palatable at the temperatures served. The cold food was warm and not palatable. Interview with the Dietary Manger on February 14, 2023, 12:50 PM, confirmed that the lunch meal was not served at acceptable and palatable temperatures . 28 Pa. Code 201.29(j) Resident rights. 28 Pa. Code 211.6(c) Dietary services.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 26142 Based on observations and a review of planned menus and staff interview, it was determined that the facility failed to ensure that food was prepared and served in a form to meet the individual needs for food texture and consistency for residents prescribed mechanically altered diets. Findings include: Observation of the lunch service tray line service on June 13, 2023, revealed that residents prescribed mechanical soft diets were to be served, ground chicken broccoli and rice with gravy. Observation revealed that the cook plated regular chicken, broccoli and rice casserole instead of the planned ground chicken and no gravy was added. The residents prescribed puree diets were to be served pureed chicken, rice and broccoli casserole with gravy and puree biscuit. The cook was observed to plate chopped chicken, pureed rice and chopped carrots. There was no gravy available on the trayline to place on the chicken. The cook placed a scoop of the regular chicken rice broccoli casserole on top of the chicken instead of gravy. There was no puree biscuit available on the tray line. During an interview June 13, 2023, at approximately 12:30 PM, the food service manager confirmed that the residents on mechanical soft and puree diets were not served the correct consistency food items during this lunch meal. He stated that the cook should not have placed the regular consistency casserole on top of the chopped chicken stating that those residents should not receive regular rice, but should have been served ground and puree consistency food. Interview with the Nursing Home Administrator on June 14, 2023, at approximately 1 PM confirmed that residents are to be served food in the form to meet their needs according to the physician order for mechanically altered diets. 28 Pa. Code 211.6 (c) Dietary Services.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records and staff interview, it was determined that the facility failed to ensure that a therapeutic altered diet was provided as ordered by the physician to meet the needs of one resident out of 29 sampled residents (Resident 125). Findings include: A review of the clinical record revealed that Resident 125 was admitted to the facility on [DATE], with diagnoses that included cerebral infarction [or a stroke, is a brain lesion in which a cluster of brain cells die when they don't get enough blood], dysphagia (difficulty swallowing), and aphagia (difficulty with communication). The resident's current physician prescribed diet, initially dated November 29, 2022, at 6:18 PM, and was NAS [(no added salt) no salt packet on meal tray] with NCS [(no concentrated sweets) prescribed to control blood sugar by limiting sugar intake] chopped diet texture (all meat is ground or chopped to reduce amount of mastication, ordered for residents with limited chewing ability and intact swallowing ability] and thin liquids diet. A review of Resident 125's lunch meal ticket for February 14, 2023, revealed that the resident's meal ticket noted chopped meat, NCS, NAS, double portions of the entree. The meal ticket indicated that the main items that were to be served that day were cucumber salad, chopped spaghetti with chopped meatballs, garlic bread (1 slice), and strawberry shortcake (1/2 portion). Observation of Resident 125's lunch tray on February 14, 2023, at 12:32 PM, revealed that there were four whole meatballs with red sauce on top of spaghetti. The meatballs should have been chopped as per the resident's mechancially altered diet. Employee 27 confirmed that the meatballs were not mechanically altered as noted on Resident 125's lunch tray ticket. The resident received a slice of strawberry shortcake that was not served as a 1/2 portion. Residents on NCS diet were to receive a 1/2 portions of cakes/pies for diabetic management. Employee 27 confirmed that the strawberry shortcake was not a 1/2 portion as noted on the resident's tray ticket. Review of the facility's diet manual that was last reviewed by the facility on February 10, 2023, revealed that chopped diet texture that meats were to be served at a ground consistency. Interview with the NHA on February 14, 2023, at 2:30 PM, confirmed that ground meatballs and a 1/2 portion of cake should have been served to Resident 125. 28 Pa. Code 211.6(b)(c) Dietary services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43944 Based on observation, review of select facility policy and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). A review of a facility policy entitled Food Storage with a policy review date of February 10, 2023, revealed that all food stock and food products are stored in a safe and sanitary manner and that all food stock are dated. All food stock and products are stored in NSF approved sanitary storage containers, or food quality plastic bags, covered, labeled as to contents, and dated. Shelving is kept clean according to the cleaning schedules and procedures. The facility policy entitled Food Preparation Area with a policy review date of February 10, 2023, revealed that the facility will maintain a clean, sanitary, and safe food preparation area. The initial tour of the kitchen was performed with Employee 6, a Dietary Supervisor, at 8:20 AM, revealed the following observations/food safety concerns: Upon entering the kitchen area, observed that there were two dietary staff members performing tasks on the breakfast tray line without hairnets. Employee 6 confirmed that hairnets were to be worn by all employees inside of the kitchen area. In the meal cart storage area there were small flies inside of the area and employee personal items that were placed on top of food preparation and storage areas, and on top of food carts, and on shelving, and on the top of a small refrigerator next to a coffee maker. There were several large open bags of cold cereals open to air, unsealed, and not dated and there were initially opened, sleeves of styro-foam cups and loose cups were scattered in the area. Dirt, food stuffs, and debris were on the floor inside this area. The bottom of the stainless-steel workstation, to the right of the staff's handwashing sink, was visibly dirty and an accummulation of dirt and debris was under and around e perimeter. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Obseration in the dish room area on the left side on the tiled wall revealed that the metal switch plate with the switch broken off. There was a build-up of a thick brownish colored substance around the perimeter of the small room entering the dish room. Inside of the dish room near the dish machine, there were several plastic dishwasher racks that were in direct contact with the floor. Tiles underneath a broken double-sided, reach-in refrigeration unit were stained with rust colored stains. Inside of the walk-in diary cooler, there were stained and soiled plastic risers. Observation inside the walk-in produce cooler, revealed the floors were visibly dirty and littered with food stuffs and debris, including onion peels and plastic wrappers. There was a collection of debris underneath the shelving and around the perimeter of the cooler. The plastic air curtain was broken and missing strips. Observation of the the walk-in freezer, revealed that threshold tiles were loose, cracked, and the grout was crumbling, and the floor had a collection of dirt and debris. The plastic air curtain had broken and missing strips. The floor around the grease trap and underneath the 3-compartment sink was stained and dirty. Small black flies were observed in this area. Employee 6 stated that grease trap has been a problem and flies are frequently in this area. There was an open box of corn starch that was not sealed on a wire rack in the cook's area. The juice gun was placed inside of a metal pan and submerged in water. Employee 6 stated that the gun was leaking. Below the juice station revealed two shelves with boxes of bulk juice coated with debris on the inside and on top of the boxes. Underneath the juice station, there was an accummulation of dirt and debris. Underneath the cook's equipment, tiles were missing grout and stained with a white substance. Also, underneath the cook's equipment there were empty food wrappers and debris. Behind the cook's equipment, there were surgical gloves and a build-up of food and debris. On top of a workstation, there was an undated open container of peanut butter and a large plastic bottle of chocolate syrup that was not sealed or dated. An accumulation of dust was observed on the fan located in the tray line area. The bottom of the stainless-steel wall panel was bent and left a gap in the wall. During observations of the kitchen performed on February 12, 2023, at 8:20 AM, with Employee 6, a Dietary Supervisor, revealed that upon entering the walk-in freezer it was observed that the tiles were loose with pieces of grout missing. Inside the freezer the area was dimly lit and was difficult to see items stored in the area. Employee 6 reported that the lights freeze up and don't all turn on. Employee 6 confirmed the above observations in the dietary department and that the kitchen area should be maintain in a sanitary manner. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Nursing Home Administrator (NHA) on February 13, 2023, at 2:45 PM, confirmed that the confirmed that the dietary department and storage areas were to be maintained in a sanitary manner and that all open items should be labeled and dated properly. 28 Pa. Code 207.2(a) Administrator's responsibility 28 Pa Code 211.6(c) Dietary services

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 41520 Based on a review of clinical records and select facility contracts and staff interview, it was determined that the facility failed to ensure that contracted services provided to residents met professional standards of practice for nurse practitioners. Findings include: A review of the facility's Medical Services Agreement effective January 1, 2021 revealed that the contracted medical service provider agrees to arrange for the availability of one or more Nurse Practitioners to provide services on-site to residents of each Designated SNF (Skilled Nursing Facility) . Medical services provided shall include all medically necessary procedures as requested by the attending physician and/or determined by the sole professional judgement of the Nurse Practitioner. Additionally, the agreement indicated that each Nurse Practitioner engaged by [contracted medical services name] to render care to residents of a Designated SNF shall be subject to the terms and conditions set forth in this Agreement. Each Nurse Practitioner engaged with [contracted medical services name] shall perform all services as to meet professional standards and principles, and shall do so in a competent, professional and timely manner. Furthermore, [contracted medical services name] shall comply with all applicable laws and regulations. According to Title 49, Chapter 21, 49 Pa. Code S 21.282a. CRNP Practice: (a) A CRNP may collaborate only with physicians who hold a current license to practice in this Commonwealth. (b) When acting in collaboration with a physician as set forth in a collaborative agreement and within the CRNP's specialty, a CRNP may: (1) Perform comprehensive assessments of patients and establish medical diagnoses. (2) Order, perform and supervise diagnostic tests for patients and, to the extent the interpretation of diagnostic tests is within the scope of the CRNP's specialty and consistent with the collaborative agreement, may interpret diagnostic tests. (3) Initiate referrals to and consultations with other licensed professional health care providers, and consult with other licensed professional health care providers at their request. (4) Develop and implement treatment plans, including issuing orders to implement treatment plans. However, only a CRNP with current prescriptive authority approval may develop and implement treatment plans for pharmaceutical treatments. (5) Complete admission and discharge summaries. (6) Order blood and blood components for patients. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(7) Order dietary plans for patients. (8) Order home health and hospice care. (9) Order durable medical equipment. (10) Issue oral orders to the extent permitted by the health care facilities' by-laws, rules, regulations or administrative policies and guidelines. (11) Make physical therapy and dietitian referrals. (12) Make respiratory and occupational therapy referrals. (13) Perform disability assessments for the program providing temporary assistance to needy families (TANF). (14) Issue homebound schooling certifications. (15) Perform and sign the initial assessment of methadone treatment evaluations, provided that any order for methadone treatment shall be made only by a physician. (c) The provisions of this section are subject to limitation as set forth in section 8.2(c.2) of the act (63 P.S. S 218.2(c.2)), regarding the authority of state agencies and health care facilities. S 21.283. Authority and qualifications for prescribing, dispensing and ordering drugs. (a) A CRNP with prescriptive authority approval may, when acting in collaboration with a physician as set forth in a prescriptive authority collaborative agreement and within the CRNP's specialty, prescribe and dispense drugs and give written or oral orders for drugs and other medical therapeutic or corrective measures. These orders may include: (1) Orders for drugs, total parenteral nutrition and lipids, in accordance with S S 21.284 and 21.285 (relating to prescribing and dispensing parameters; and prescriptive authority collaborative agreements). (2) Disposables and devices adjunctive to a treatment plan. (b) To obtain prescriptive authority approval, a CRNP shall: (1) Successfully complete at least 45 hours of course work specific to advanced pharmacology in accordance with the following: (i) The course work in advanced pharmacology may be either part of the CRNP education program or, if completed outside of the CRNP education program, an additional course or courses taken from an educational program or programs approved by the Board. (ii) The course work shall be at an advanced level above a pharmacology course required by a professional nursing (RN) education program. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(iii) The course work shall have been completed within 5 years immediately preceding the date the applicant applies for initial prescriptive authority approval. (2) Submit an application for prescriptive authority approval to the Board. (3) Pay the fee set forth in S 21.253 (relating to fees). (c) A CRNP who has prescriptive authority shall complete at least 16 hours of Board-approved continuing education in pharmacology in the 2 years prior to the biennial renewal date of the certification. The CRNP shall verify completion of the continuing education when submitting a biennial renewal. Review of the Pennsylvania State Board of Nursing website revealed that Employee 9, the facility's contracted CRNP was licensed, but there was no indication of a collaborative agreement with a physician or prescriptive authority. Interview with the Nursing Home Administrator on February 14, 2023 at approximately 2:30 PM verified that Employee 9, Certified Registered Nurse Practitioner, was providing medical care to residents as a contracted CRNP, performing resident assessments, ordering medications and making medication adjustments for residents. Upon request of the collaborative agreement and prescriptive authority the facility was unable to provide evidence as of the conclusion of the survey on February 15, 2023. Interview with the Nursing Home Administrator on February 15, 2023, at 3:30PM confirmed the contracted CRNP did not meet the standards to practice according to CHAPTER 21. STATE BOARD OF NURSING. 28 Pa. Code 201.21(c) Use of outside resources

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 26142 Based on review of the facility's plan of correction from the survey ending February 15, 2023, the directed plan of correction planned by the State Survey Agency and the findings of the revisit survey ending June 14, 2023, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to assure that effective plans are developed and implemented to correct identified quality deficiencies in infection control and nutrition services. The facility further failed to complete the remedy of the directed plan of correction as required to correct and prevent further quality deficiencies in infection control. Findings include: A review of the statement of deficiencies and facility's plan of correction for the survey ending February 15, 2023, revealed that the facility developed a plan of correction that included quality assurance monitoring systems to ensure that solutions were sustained. The results of the current survey ending June 14, 2023, identified continued quality deficiencies related to infection control and food and nutrition services. Additionally, it was identified that the facility failed to complete and implement their directed plan of correction for the infection control imposed as a remedy by the State Survey Agency following the survey ending February 15, 2023. Quality deficiencies were cited during the surveys of February 15, 2023, and April 27, 2023, under the requirements for food and nutriton services department including sanitary practices for the preparation, storage and service of food, therapeutic diets, following planned menus, food served in a form to meet individual needs, palatable temperatures and overall management and supervision of the operations of the facility's food and nutrition services department continued at the time of the the current revisit survey ending June 14, 2023. During an interview June 14, 2023 at approximately 1 P.M., the Nursing Home Administrator confirmed that the facility's plan of correction, required dietary staff to clean and sanitize the kitchen per the schedule. In addition the dietary staff were to be re-educated on the facility's dietary cleaning policy and these administrative staff members were unable to state why the quality deficiencies continued in the food and nutrition services department. The facility's quality assurance monitoring plans failed to identify the continuing deficient practice. In response to deficiency cited under infection control cited during the survey ending February 15, 2023, the facility was directed to complete the following paln of correction: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Infection Preventionist and Director of Nursing will complete CDC-NHSN training to Use the Long Term Care Facility (LTCF) Component to track infections and prevention process measures, systematically, to identify problems, improve care, and determine progress toward national healthcare-associated infection goals. Completion Date identified by the facility was March 24, 2023 The Infection Preventionist and Director of Nursing, each day and more often as necessary, will review infection prevention tracking and trending. Any unexpected increases in infection will result in communication with the Medical Director, Public Health Department and the state survey agency in order to obtain further assistance to control infection. Such monitoring will continue until the facility has been COVID infection free for at least four weeks. Completion Date identified by the facility was April 11, 2023 The comprehensive program to monitor and prevent infections in the facility will be audited weekly x 4 and monthly x2. Completion Date identified by the facility April 11,2023 The Infection Preventionist, Director of Nursing and other nursing leadership, will conduct rounds throughout the facility to ensure staff is exercising appropriate use of personal protective equipment and to ensure infection control procedures are followed on the unit. Ad hoc education will be provided to persons who are not correctly utilizing equipment and/or infection prevention/control practices. Such monitoring will continue until the facility has been infection free for at least four weeks. Will review infection prevention tracking and trending, and any unexpected increases in infection will result in communication with the Medical Director and The State Survey Agency in order to obtain further assistance to control infection. Completion Date identified by the facility- April 11,2023 Conduct a root cause analysis of the non-compliance cited, which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA will include identifying a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, and visitors following accepted standards and guidelines. Completion Date identified by the facility March 14,2023 There was no documented evidence at the time of the revisit survey ending June 14, 2023, that the facility had completed any of the components noted above to fulfill the required directed plan of correction. During an interview June 14, 2023 at approximately 1 P.M., the Director of Nursing confirmed that the directed plan of correction imposed by the State Survey Agency following the February 13, 2023 survey for the deficiency in infection control had not been completed directed by the State Survey Agency. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's QAPI committee failed to identify that the facility had failed to complete the directed plan of correction as directed by the State Survey Agency. Continued deficient practice was identified in the area of infection control during this revisit survey ending June 14, 2023. The facility's QAPI committee failed to identify that the facility had failed to implement their plan of correction, in a manner consistent with the regulatory guidelines for the deficiencies cited, to ensure that solutions to the problem were sustained and to improve the delivery of care to residents. Refer F800, F804, F805, F808, F812, F880 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 201.18 (d)(3)(e)(1) Management. 28 Pa. Code 201.14 (e) Responsibility of Licensee

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 26142 Based on review of facility documents and staff interviews, it was determined that the facility failed to ensure that the Medical Director or designee was in attendance at quarterly Quality Assurance Process Improvement (QAPI) Committee meetings for two of four quarters (June 2022 through January 2022) Findings include: A review of QAPI Committee meeting sign-in sheets for the period of June 2022 through January 2022, revealed that the Medical Director or other physician was not in attendance, virtually or in-person, at the QA meetings held from June 2022 through January 2023, missing 7 monthly meetings (June 2022 through January 2023). Interview with the administrator on February 15, 2023, at 12:00 PM confirmed that the a physician failed to attend the facility's QAPI meetings on a quarterly basis. 28 Pa. Code 211.2(d)(2) Physician Services 28 Pa. Code 201.18(e)(1)(2)(3) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 26142 Based on review of clinical records and the facility's infection control data, infection control program and policy and staff interview, it was determined that the facility failed to maintain a comprehensive program to monitor and prevent infections in the facility. Findings include: A review of the facility's current infection control policy provided during the survey ending February 15, 2023, revealed that it is the policy of the facility to 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 or communicable diseases and infections. A review of facility infection control logs for April 2022 revealed that there were seven influenza A infections among residents of the facility. These logs did not include at the facility's response to this influenza outbreak, including evidence that the infections were tracked, potential trends explored and the interventions implemented with residents and staff to prevent the spread of the infection. A review of the facility's infection data since the last standard survey ending March 4, 2023, during the months from April 2022 through January 2023 multiple resident infections were identified each month. There was no documented evidence that the potential had evaluated potential causative factors and tracked the infections for any potential patterns or trends and the corresponding applicable interventions initiated to prevent occurrence of infection. A review of monthly infection tracking logs dated September 2022 through January 2023 indicated multiple infections noted each month. There was no descriptive information on the listings to include symptoms, culture or testing, organisms identified, completed treatment information or resolution dates. There was no tracking or trending information available at the time of the survey for the months of April 2022 through January 2023 to analyze trends to prevent spread of infection in the facility. There was no indication that the limited infection data that the facility had compiled was then evaluated to determine what could be done to prevent the spread or recurrence of infection. The facility failed to demonstrate that its infection control program included, at a minimum, a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, and visitors following accepted standards and guidelines. Interview on February 14, 2023, at 10 AM with the facility Infection Control Nurse confirmed that the facility's current infection control program did not meet the intent of the requirements contained in the long term care regulations. 28 Pa Code 211.10 (a)(d) Resident care policies. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 26142 Based on a review of clinical records and the facility's infection control policies and staff interview it was determined that the facility failed to maintain an antibiotic stewardship program that includes a system to effectively monitor antibiotic usage as evidenced by one of five sampled residents (Resident CR1). Findings include: A review of the facility policy for Antibiotic Stewardship, dated as reviewed February 2023, revealed that antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of the antibiotic steward ship program is to monitor the use of antibiotics in our residents. When a culture and sensitivity is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified or discontinued. A review of Resident CR1's clinical record revealed a physician order dated July 2, 2022, to obtain a urine culture and sensitivity. A review of a laboratory report dated July 4, 2022, revealed greater than 100,000 Proteus Mirabilis organism. A review of laboratory test results, dated July 4, 2022, revealed that the identified organism was resistant to treatment with Levaquin A physician's order dated July 5, 2022, was noted for Levaquin (Levofloxacin) 750 mg daily for urinary tract infection for 5 days. A review of the resident's medication administration record for the month of July 2022, revealed that the resident received two doses of Levaquin prior to its discontinuation on July 7, 2022. Nursing contacted the physician on July 7, 2022, and the physician stated to discontinue Levaquin, and to start Ceftriaxone sodium solution 1 gm, daily for days for a UTI (urinary tract infection). A physician order, dated July 7, 2022, was noted to discontinue Levaquin, and to start Ceftriaxone sodium solution 1 gm, daily for days for a UTI (urinary tract infection). There was no evidence at the time of the survey of a functioning antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use to prevent unnecessary antibiotic use. During an interview February 15, 2022 at 1 P.M., the Director of Nursing confirmed that the resident received unnecessary doses of antibiotics. Refer F757 28 Pa. Code 211.12 (a)(c)(1)(3)(5) Nursing services 28 Pa. Code 211.2(a) Physicians services (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10 (a) Resident Care Policies

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 select facility policy and clinical records, and staff interview, it was determined that the facility failed to offer and/or provide the flu and pneumococcal immunization, unless the immunization was medically contraindicated or the resident has already been immunized, to two of 29 residents reviewed (Residents 25 and 93) Findings include: A review of facility policy entitled Influenza Vaccine last reviewed February 2023, revealed all residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccines against influenza. Prior to the vaccination the residents or their representatives will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. for the residents who received the vaccine the date of the vaccine, lot number, expiration date, person administering, and site of the vaccination will be documented in the residence medical record. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. A review of Resident 25's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included kidney disease and dementia (the impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Further review of the resident's clinical record revealed no documented evidence that Resident 25 was offered or vaccinated for influenza. There was no evidence that the facility provided information and education regarding the benefits and side effects of the influenza vaccine or any documentation that the resident had refused the vaccine. A review of Resident 93's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses which included metabolic encephalopathy (chemical imbalance in the blood that affects the brain which can cause loss of memory and difficulty coordinating motor tasks) and muscle weakness. Further review of the resident's clinical record revealed no documented evidence that Resident 93 was offered or vaccinated for influenza. There was no evidence the facility provided information and education regarding the benefits and side effects of the influenza vaccine or any documentation that the resident had refused the vaccine. Interview with the Director of Nursing (DON) on February 14, 2023, at approximately 2:00 PM revealed that the influenza vaccines were administered in October 2022, and confirmed the facility failed to offer and provide influenza immunizations to all residents. 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa Code 211.5 (f)(h) Clinical records (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa code 211.12 (a)(c)(d)(1)(5) Nursing Services

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of clinical records and resident and staff interview it was determined that the facility failed to offer and/or provide the COVID-19 immunization to one of five residents reviewed for immunizations (Resident 78). Findings include: Clinical record review revealed that Resident 78 was admitted to the facility on [DATE], at 11:20 AM for therapy services. There was no documented evidence in the resident's clinical record that Resident 78 had received the COVID-19 vaccine prior to admission to the facility or was offered the COVID-19 vaccine. In addition, there was no evidence of any education provided to the resident or representative regarding the COVID-19 vaccine. A review of facility documentation provided to the survey team regarding resident COVID-19 vaccination status revealed 26 residents in the facility without COVID-19 vaccination status identified Interview with the Director of Nursing on February 15, 2023 at approximately 1:00 PM confirmed that the facility was unable to confirm the COVID-19 vaccination for Resident 78 as well as the additional 25 residents documented on the facility COVID-19 resident vaccination form and that the resident's clinical record failed to provide evidence that the vaccine had been administered. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.12 (c) Nursing services. 28 Pa. Code 211.10(a)(d) Resident care policies

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure staff are vaccinated for COVID-19 26142 Based on a review of select facility policy, the Centers for Medicare and Medicaid directives, employee vaccine data, and staff interviews, it was determined the facility failed to fully develop and implement policies and procedures to ensure that all staff were vaccinated for COVID-19. The facility's staff vaccination rate was 99.4% at the time of the survey ending February 15, 2023. Findings include: A review of a DEPARTMENT OF HEALTH & HUMAN SERVICES, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group dated October 28, 2022, QSO 23-02-ALL memo stated that within 60 days after the issuance of this memorandum the facility demonstrates that policies and procedures are developed and implemented for ensuring all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19; and 100% of staff have received the necessary doses to complete the vaccine series (i.e., one dose of a single-dose vaccine or all doses of a multiple-dose vaccine series), or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the facility is compliant under the rule; or Less than 100% of all staff have received at least one dose of a single-dose vaccine, or all doses of a multiple-dose vaccine series, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the facility is noncompliant. A review of a DEPARTMENT OF HEALTH & HUMAN SERVICES, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group dated October 28, 2022, QSO 23-02-ALL memo stated, Vaccination Enforcement: Medicare and Medicaid-certified facilities are expected to comply with all applicable regulatory requirements, and CMS has a variety of established enforcement remedies. For nursing homes, home health agencies, and hospice (beginning in 2022), this includes civil monetary penalties, denial of payments, and-as a final measure-termination of participation from the Medicare and Medicaid programs. The sole enforcement remedy for noncompliance for hospitals and certain other acute and continuing care providers is termination; however, CMS ' s primary goal is to bring health care facilities into compliance. Termination would generally occur only after providing a facility with an opportunity to make corrections and come into compliance. CMS expects all providers ' and suppliers ' staff to have received the appropriate number of doses of the primary vaccine series unless exempted as required by law, or delayed as recommended by CDC. Facility staff vaccination rates under 100% constitute noncompliance under the rule. Noncompliance does not necessarily lead to termination, and facilities will generally be given opportunities to return to compliance. For example, a facility that is noncompliant and has implemented a plan to achieve compliance would not be subject to an enforcement action. A review of a facility policy for Employee Vaccination, revised October 2022, revealed, It is the policy of this facility that effective February 14, 2022 - March 14, 2022, all staff must have received at least one dose, or have been granted/have a pending request for a qualifying exemption, or identify as having a temporary delay. Effective March 15, 2022 and thereafter, all staff are required to have received at least one dose of a single dose vaccine, or all doses of a multiple vaccine series, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC (QSO-22-09-ALL, updated on January 20, 2022). (continued on next page)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure 1. The infection Preventionist or designee will complete a roster of all eligible staff and current vaccination status. 2. The infection Preventionist of designee, will identify employees who do not meet the definition of fully vaccinated. 3. The infection Preventionist or designee, will contact each employee who does not meet the definition of fully vaccinated to determine: a. if eligible staff has received one-dose of the two-dose series and has an appointment for the second dose. b. if eligible staff has an appointment to receive the single-dose COVID-19 vaccine. c. if eligible staff requests a medical or religious exemption, employees will be informed of the facility's process to request and to be granted an exemption. Documentation for exemptions for becoming vaccinated for COVID-19 include, medical condition, contraindications including staff who have a temporary delay of COVID-19 vaccinations in accordance with the CDC. Documentation must be signed and dated by a licensed practioner that includes: a. All information specifying which of the COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications, and b. A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications. c. If eligible staff (other than employees with valid exemptions) refuses to be vaccinated or request exemption with a COVID-19 first dose of a 2 dose series, or a dose of a 1 dose COVID-19 vaccine by March 14, 2022, employees will be subject to final written and disciplinary action. A review of the facility staff vaccination data revealed that Employee 11, housekeeping, was only partially vaccinated at the time of the survey of February 15, 2023. Further review of the employee's vaccination status revealed that Employee 11 received her first dose, of a two dose series of the COVID-19 vaccine, on September 12, 2022. However, as of the time of the survey ending February 15, 2023, Employee 11 had not received her second dose of the 2-dose COVID-19 vaccination series. According to facility documentation Employee 11 was hired on September 6, 2022, and vaccinated six days after she was hired at the facility. A review of the facility staff vaccination data revealed that Employee 12, dietary, was only partially vaccinated at the time of the survey of February 15, 2023. Further review of the employee's vaccination status revealed that Employee 11 received her first dose of a two dose series of the COVID-19 vaccine on October 6, 2022. However, as of the time of the survey ending February 15, 2023, Employee 12 had not received her second dose of the 2-dose COVID-19 vaccination series. As a result, the facility's staff vaccination rate for facility staff was 99.4%. (continued on next page)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility form entitled, Medical certification for COVID-19 vaccine accommodation dated November 23, 2022 indicated that Employee 13, a nurse aide, had requested a medical exemption from the COVID-19 vaccine. The form indicated that the as per the employee's preference, chooses not to get the vaccine. She feels uncomfortable due to her asthma. The form indicated no other medical condition that would limit the individual from receiving any COVID-19 vaccine. The form was signed as approved by the employee's physician. A review of a facility form entitled, Medical certification for COVID-19 vaccine accommodation dated November 23, 2022 indicated that Employee 14 (housekeeping) had requested a medical exemption from the COVID-19 vaccine. The form indicated that as per the employee, he had severe anxiety and phobia to the COVID-19 vaccine. The patient does not have any communicable diseases. The form indicated no other medical condition that would limit the individual from receiving any COVID-19 vaccine. The form was signed as approved by the employee's physician. The facility failed to implement a process for ensuring that all documentation confirms recognized clinical contraindications to COVID-19 vaccines to supports staff requests for medical exemptions from vaccination. A review of NHSN reported data dated January 29, 2023, revealed that the facility COVID-19 staff vaccination percentage rate was 90.8 %. At the time of the end of survey on February 15, 2023, the facility policy and procedures for staff COVID-19 vaccinations had not been fully implemented. Interview with the Director of Nursing on February 15, 2022, at 12:00 PM confirmed the facility did not fully implement a COVID-19 vaccination policy to include timeframes for newly hired partially vaccinated staff to receive all doses of the vaccine series and the first dose prior to employment at the facility of their vaccination series and to ensure . The facility confirmed that the current staff vaccination rate was less than 100% with qualifying exemptions. 28 Pa. Code 201.14 (a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1)(d)(e)(1) Management 28 Pa. Code 211.12 (c) Nursing Services

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 26142 Based on observation and staff interview revealed that the facility failed to maintain a safe, functional, and sanitary environment on the currently licensed and certified B1 and C1 resident units. Findings: An observation February 12, 2023 at 9.M. revealed that the beds on the licensed and certified B1 resident unit were unmade and dirty. The floors in all the resident rooms on the unit and hallways were littered with dirt, paper debris with dried liquid stains. The temperature on the unit felt cold. The call bell system on the B1 and C1 units was not operational in all resident rooms. In resident room B 116, there was a heater filter observed on the floor, which was covered with a thick layer of lint and dirt. In room B 110, the heating unit was taken apart with the front cover off. There was no mattress on the resident bed in the room. In resident room B 126, which is licensed as a double room, there was only one bed in the room. In resident room B 161, the heating unit in the room was broken. In resident room B 155 heating unit was broken and the filter was covered with a thick layer of lint and dirt. In resident rooms 164, 165, 167, 168 and 170, the window curtains were ripped and removed from the windows and were laying on the unmade beds in the resident rooms. Observations of the Resident C1 resident unit February 12, 2023 at 9 A.M. revealed no mattresses on any of the resident beds. The required furniture, beds, dressers and overbed tables were missing from the rooms or broken. The call bell system was inoperable in most of the resident rooms. The soap dispenser was broken in resident room C 115. There were ceiling tiles removed in the hallway ceiling outside of room C 158 exposing the pipes in the ceiling. The broken ceiling tiles were observed on the floor below. In resident room C 156 the resident bed was broken. The base board under the resident sink was missing. In resident room C 124 and C 119, the heating unit was missing, exposing the area to the outside elements. (continued on next page)

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	395414	A. Building B. Wing	02/15/2023

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

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In resident resident room C 108, there was a black substance on the floor and a broken heating unit across the floor to the wall. The base boards were missing under the resident sink. There was no running cold water in the resident sink in the room. In room C 153's shared bathroom/shower room, there was a linen cart containing clean resident linen, towels, washcloths, sheets pillowcases and hospital gown. During the observation, a staff member entered the room and removed the clean linen cart. Interview with the staff member at that time revealed that clean resident linen was stored in this location for use on other resident floors. The facility failed to maintain these licensed and certified resident units in a manner to readily allow resident occupancy and to be occupied by residents if necessary for cohorting purposes for potential outbreaks of infection. The facility stored clean resident linen in this unsafe and unsanitary environment, which was accessed by facility staff. During an interview February 12, 2023 at approximately 12 P.M., the facility maintenance director confirmed the unsanitary conditions on these units and that the resident units were not readily available for resident occupancy. The maintenance director confirmed that staff continue to access the units and store clean resident linens in this area. 28 Pa. Code 201.14 (a) Responsibility of Licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 207.2(a) Administrator's responsibility

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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. 43944 Based on review of the facility's pest management contract, select facility policy, and pest control logs, observations, and resident and staff interviews it was determined that the facility failed to maintain an effective pest control program. Findings include: Review of the Pest Management Proposal dated, January 12, 2023, provided at the time of the survey ending February 15, 2023, indicated that the pest management proposal included having a fixed schedule for regular services, at a time when you are present. The Scope of Service included that service will be provided on a consistent schedule, weekdays between 8:00 AM and 5:00 PM. The same technician will perform all services with the exception of emergencies. The kitchen, dining room, staff cafeteria, vending machine areas, and nursing stations will be serviced on a regular basis; all other areas will be services as necessary. Covered pests include mice, rats, ants and roaches. Interior and exterior deficiencies will be noted and reported to your maintenance personnel. These deficiencies may include structural concerns, gaps under doors, holes in walls, screens, around pipes, crevices around windows or doorways, faulty downspouts, etc. These areas of concern will need to be addressed by your maintenance staff in order to reduce the potential of ongoing pest problems. Review of the facility policy entitled Pest Control with a policy review date of February 10, 2023, indicated that it is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. The definition of Effective pest control program is defined as measures to eradicate and contain common household pests (e.g. bed bugs, lice, roaches, ants, mosquitos, flies, mice and rats). Basic prevention and control measures include that food should be covered or stored in airtight pest proof containers, spillage should be promptly removed, accumulation of stagnant water should be avoided and/or eliminated. Drains should be covered; leaking pipework repaired, and damaged surfaces made good. Additionally, cracks in plaster, woodwork, unsealed areas around pipework, damaged tiles and badly fitted equipment are all likely to provide excellent harborage and therefore should be maintained in a stable condition and defects should be reported to the Maintenance Director. The procedure notes, the Maintenance Director is the designated pest management coordinator for the facility and will act as liaison between the facility and the pest management professionals. Any sightings of pests or evidence of their existence should be reported to Maintenance Director immediately. The facility will maintain a report system of issues that may arise in between scheduled visits with the outside pest service and treat as indicated. Observations of the kitchen on February 12, 2023, at 8:20 AM, with Employee 6, a Dietary Supervisor, revealed that in the meal delivery cart storage area there were small flies inside of there were several large open bags of cold cereals (used for the residents) that were not in a sealed container. An accumulation of food stuffs and debris was scattered on the floor. Upon entering the walk-in freezer, observed that the threshold tiles were loose, cracked, and the grout was crumbling, and the floor had a collection of dirt and debris. Also, the plastic air curtain had broken and missing strips. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The floor around the grease trap and underneath the 3-compartment sink was stained and dirty and small black flies were observed in the area. Employee 6 stated at that time that the grease trap had been a problem and that the flies are present frequently in this area. The juice gun was placed inside of a metal pan and submerged in water. Employee 6 stated that the juice gun had leaking. Underneath the cook's equipment, observed that there were tiles with grout missing and stained with a white substance. Also, underneath the cook's equipment there were empty food wrappers and debris. Behind the cook's equipment, an accummulation of food debris was observed. Observation upon exiting the kitchen area revealed that the bottom of the stainless-steel wall panel was bent and left a gap in the wall. During a group meeting with residents on February 14, 2023, at 10:26 AM, Resident 7 and Resident 116 reported seeing many small black flies in the resident dining room next to the kitchen area and on their units (C-2). Interview with the Nursing Home Administrator (NHA) on February 15, 2023, at 11:15 AM, confirmed that the facility was unable to demonstrate could regular maintenance was conducted in the kitchen area to control insects. Through survey ending February 15, 2023, at 3:00 PM, the facility was not able to provide documented evidence that a treatment plan that addressed the small black flies in the kitchen area had been developed and that regular treatments were performed to control and prevent small flies in food preparation areas. 28 Pa. Code 207.2 (a) Administrator's responsibility 28 Pa. Code 201.18 (a)(c)(e)(2) Management

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 41581 Based on staff interviews and a review of employee records it was determined that the facility failed to timely train four agency employees out of four reviewed on the facility's specific abuse prohibition policy and procedures. Findings include: An interview with Employee 2, an agency nurse aide, on February 14, 2023, at approximately 9:50 AM revealed that the employee stated it was her second day working in the facility and she was not yet provided orientation or training on the facility's abuse policy prior to working on the nursing unit with the residents. An interview with Employee 3, an agency licensed practical nurse, on February 14, 2023, at approximately 4:40 PM revealed the employee stated she has been working in the facility, as needed, for about a year and works whatever shifts they need. Employee 3 stated she did not receive any training prior to working the nursing units with the residents and that she was never trained on the facility's abuse policy. An interview with Employee 4, an agency nurse aide, on February 14, 2023, at approximately 4:45 PM revealed that the employee stated she has been working in the facility for around a year and she was never trained the facility's abuse policy prior to working with the residents. An interview with Employee 5, an Agency LPN on February 14, 2023, at approximately 4:50 PM revealed that the employee stated she has been working at the facility for 2 weeks. The employee stated she was had not been trained the facility's abuse policy prior to working on the nursing units. There was no documented evidence that the facility provided agency staff abuse training on the facility specific abuse prohibition policies and procedures prior to working on the nursing units with residents. An interview with Nursing Home Administrator on February 15, 2023, at approximately 9:50 AM confirmed there was no documentation that Employees 2, 3, 4, and 5 were trained on the facility's abuse prohibition policy and procedures prior to assuming their job duties. 28 Pa. Code 201.20(b) Staff development 28 Pa Code 201.18 (e)(1) Management 28 Pa. Code 201.29(a)(c) Resident rights