STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395421	A. Building B. Wing	08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Brook Rehabilitation and Healthcare Center	801 East 16th Street Berwick, PA 18603

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 26142 Based on select facility policy review and staff interviews, it was determined that the facility failed to fully develop an abuse prohibition policy with corresponding written procedures to assure staff carry out the tasks necessary to fulfill required components for screening, training, prevention, identification, investigation, protection and reporting/response to allegations of resident abuse. Findings included: A review of the facility abuse policy entitled Abuse Prevention Program adopted March 31, 2021, revealed that Our residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility policy defined abuse and neglect, but failed to define additional types of abuse such as involuntary seclusion and misappropriation of resident property. The facility abuse prohibition policy provided to the survey team at the time of the survey ending August 19, 2021, did not contain components for screening potential employees to include, previous employment information, reference checks and registry/licensing agency checks. The facility failed to identify state specific requirements if potential employees had resided in Pennsylvania for the previous 2 years, and if not conduct a FBI (Federal Bureau of Investigation) criminal background check. The policy failed to include procedures for assuring required abuse training, including time frames, for employees upon hire and yearly on the facility specific abuse policy. The policy stated that the administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. However, did not specify a procedure for staff to follow to meet this policy statement. The policy abuse reporting component revealed that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown will be reported by the facility administrator, or his/her designee, to the following persons or agencies. a. The state licensing/certification agency responsible for survey/licensing the facility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. The local/state ombudsman c. The residents representative d. adult protective services(where state law provides jurisdiction in long-term care) e. law enforcement officials f. The resident's attending Physician g. The facility medical director An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two hours if the alleged violation involves abuse OR has resulted in serious bodily injury or b. 24 hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. The facility abuse does not include the criteria for notifying the local Area Agency on Aging or State Department of Aging. The policy did not include procedures making the state nurse aide registry and licensing agencies aware of any actions taken by the courts regarding an employee unfit for duty, and the police notified for the following criteria, physical bodily injury, sexual abuse, misappropriation of resident funds/property and unexplained/unexpected deaths. The facility's policy for Investigating injuries revealed that The administrator will ensure that all injuries are investigated. With the help of the staff and management, the investigator will compile a list of all personnel, including consultants, contract employees, visitors, family members, etc, who have had contact with the resident during the past 48 hours. The investigation will follow the protocols set forth in our policy's established abuse investigation guidelines. However, there was no documented evidence at the time of the survey ending August 19, 2021, that the facility's policy included written procedures for implementation by staff to investigate allegations of abuse, timeframes for investigation and reporting and staff training requirements. The facility's abuse prohibition policy provided to the survey team during the survey ending August 19, 2021, did not contain necessary procedures to fulfill all regulatory required components of an abuse prohibition policy. There was no documented evidence that the facility's abuse policy included written procedures to meet all required components including screening, training, prevention, identification, investigation, protection or reporting procedures. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview August 19, 2021, at approximately 2 PM, the facility's administrative staff was unable to provide evidence of written procedures to meet the requirements of an abuse prohibition policy and procedure. Refer F610 28 Pa. Code 201.14(a)(c)(e) Responsibility of Licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c)(d) Resident rights

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456 Based on a review of clinical records, the facility's abuse prohibition policy and information provided by the facility, it was determined the facility failed to implement procedures for conducting a thorough investigation of injuries of unknown origin for two residents out of 19 residents reviewed (Resident 1, 19 and 6) and failed to report the results of all investigations related to the potential abuse for 5 residents out of 19 residents reviewed. (Residents CR2, 10, 14, 17 and 18) Findings include: A review of the facility policy adopted by the facility March 31, 2021 entitled Investigating Injuries indicated that the nursing home administrator will ensure that all injuries are investigated. The policy further stated; 1. The director of nursing services or designee will assess all injuries and document findings in the clinical record. 2. If an incident/accident is suspected, a nurse or nurse supervisor will complete a facility-approved accident/incident form. 3. Injury of Unknown Source is defined as an injury that meets both of the following conditions: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and b. the injury is suspicious because of: (1) the extent of the injury; or (2) the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); or (3) the number of injuries observed at one particular point in time; or (4) the incidence of injuries over time The policy further indicated: Documentation shall include information relevant to risk factors and conditions that could cause or predispose someone to similar signs and symptoms such as receiving blood thinners. Any descriptions in the medical record shall be objective and sufficiently detailed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nursing staff will discuss the situation with the attending physician or medical director to consider whether medical conditions or other risk factors could account for the findings. The medical director or attending physician shall review and verify conclusions about the possibility of a medical or other similar cause of the findings. With the help of the staff and management investigators will complete a list of all personnel including consultants, contract employees, visitors, family members etc., who have had contact with the residents during the past 48 hours. The investigation will follow the protocols set forth in the faciltiy's established abuse investigation guidelines. A review of the clinical record revealed that Resident 1 was admitted to the fcaility on December 14, 2020, with diagnoses, which included difficulty walking and muscle weakness. A quarterly MDS (minimum data seta federally mandated standardized assessment conducted at specific intervals to pan resident care) dated July 2, 2021 indicated he had a BIMS of 5 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 00-07 equates to severe cognitive impairment. The MDS further indicated that the resident was not able to walk independently or move from a seated to standing position without the assistance of staff. A review of Resident 1's clinical record revealed documentation dated July 6, 2021 at 9:16 AM, which indicated that the resident was found with a bruise to the left side of his face measuring 1 inch long by 0.5 inches wide and was yellow in color. The facility's investigation revealed staff statements solely indicating that the resident was found with a bruise. Nursing documentation later that date at 10:52 AM on July 6, 2021, revealed that the resident's roommate, who was cognitively aware, reported that that Resident 1 fell the other night. The facility's investigation concluded that the resident's bruise occurred due to the fall. However, the facility failed to conduct an investigation into how this resident, who was identified at high risk for falls, had fallen and sustained the injuries side of his face. At the time of the survey ending August 19, 2021, the facility was unable to provide documented evidence of a complete and thorough investigation into the circumstances surrounding the resident's facial bruise. Nursing documentation dated July 14, 2021, at 1:35 PM revealed that Resident 1 had 3 red marks, one on his right elbow, one measuring approximately 1 cm x 1 cm, another 1 inch long down the middle of his back and another red mark on his sacrum measuring 1 cm x 1 cm. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility documentation indicated that the assistant director of nursing (ADON) and Employee 4, a licensed practical nurse (LPN only identified by her first name) found him the resident the floor. The documentation did not identify the location the resident was found (such as the floor of his room, bathroom or common area) or the circumstances as to how the resident may have sustained the injuries. A review of the Resident 19's clinical record revealed admission to the facility on [DATE], with diagnoses of high blood pressure, major depression and anxiety. The resident had a BIMS of 15 which indicated that she was cognitively intact. A review of facility documentation dated August 2, 2021, indicated that Resident 19 had a large bruise on her right outer arm. The documentation did not indicate the size of the bruise. The documentation indicated that the resident that stated she woke up with the bruise. The facility did not further investigate the injury of unknown origin to rule out abuse, neglect or mistreatment as a potential cause of the injury. A review of the clinical record revealed that Resident 6 was readmitted to the facility on [DATE] with diagnoses to included Cerebral infarction (stroke), Muscle weakness and Cognitive communication deficit. A quarterly Minimum Data Set assessment dated [DATE] revealed that Resident 6 was severely cognitively impaired. A review of nursing documentation dated August 10, 2021, at 12:59 PM revealed Resident 6, was brought to nursing station in wheelchair and staff members noticed bruise on the resident's left hand approximately 2 cm x 2 cm. The resident denied pain and was unable to state how he got the bruises. There was no documented evidence at the time of the survey ending August 19, 2021, that the facility had investigated Resident 6's bruise on his left hand, an injury of unknown origin, to rule out abuse. During an interview August 19, 2021 at approximately 3 PM the interim Director of Nursing confirmed that no investigation was conducted to rule out abuse of Resident 6. The ADON confirmed during interview on August 19, 2021, that the facility had no additional documentation to show that the facility had thoroughly investigated the injuries of unknown sources and unwitnessed incidents to rule out abuse, neglect or mistreatment as the potential cause of the injury. A review of the facility policy entitled Abuse Investigation and Reporting dated as reviewed August 2021 indicated that all reports of abuse, neglect, exploitation, misappropriation of resident property, mistreatment and or/injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. The policy further states the administrator, or his/her designee will provide the appropriate agencies with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to review of incidents of abuse, neglect and misappropriation of property, the facility reported to the State Survey Agency via the Electronic Reporting System(ERS) the facility failed to report the findings and potential corrective actions of the following allegations of abuse, by submitting a PB22 (Pennsylvania Bulletin 22- form used to detail investigation ,findings and actions) within five working days of occurrence: On May 8, 2021, the facility reported that Resident CR2 was struck by another resident in the hallway. It was reported by the facility, on June 11, 2021, that a peer grabbed the hand of Resident 14, to propel herself around a tray table that was causing an obstacle to her ability to maneuver in the hallway. Resident 14 responded by slapping the resident. The facility reported on June 30, 2021, that Resident 10 reported that her roommate, Resident 16, hit her in the forehead. When the resident was examined redness to her right eye was observed. On 7/19/21, the facility reported that Resident 17's daughter reported that the resident complained that she is frightened of her roommate. The resident alleged that her roommate bumps into her bed at night, grabs her hands, lifts her hands/fists up in a threatening manner and takes her food. The facility reported on July 23, 2021, that a staff member, employed as a temporary nurse aide, was engaged in a hand Tussle with Resident 18. The person who observed and reported the incident, stated that the perpetrator was holding the resident's hand tightly and the resident stated she wanted the perpetrator to stop. The facility failed to submit the results of their investigations into the above instances of alleged resident abuse to the State Survey Agency within 5 working days of the occurrence. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29 (c)(d) Resident Rights 28 Pa. Code 211.10 (c) Resident care policies

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456 Based on review of clinical records and staff interviews it was determined that the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure licensed nurses thoroughly assessed and evaluated a resident's wounds to ensure the resident received the necessary care and services and implemented physician orders for one resident (Resident CR1) out of 20 residents reviewed. Findings included: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient ' s EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: Assessments Clinical problems Communications with other health care professionals regarding the patient Communication with and education of the patient, family, and the patient ' s designated support person and other third parties. Review of Resident CR1's clinical record revealed admission to the facility on [DATE], with diagnoses that included left below the knee amputation (completed on May 6, 2021), bacteremia (blood infection), abscess of the right foot, and diabetes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident CR1's Hospital discharge record dated May 11, 2021, revealed that the resident was to continue on his home medications in addition to Vancomycin intravenously every 24 hours for 10 days, an oral probiotic daily, follow-up with wound care center within 1 week, and continue would care as directed. Further review of the resident's hospital records revealed that the resident had a right foot ulcerated wound that appeared to be healing on plantar surface. Review of physician progress note dated May 11, 2021, revealed that the resident was ordered to follow-up with wound care. Review of Resident CR1's admission physician orders dated May 11, 2021, revealed that from May 11 to May 18, 2021, there were no orders for treatment to the resident's LBKA surgical site. Further review revealed that from May 11 to May 13, 2021 there were no orders for treatment to the resident's right foot vascular wound(s). There was no order for wound care center follow-up or for a probiotic daily. Review of Resident CR1's admission skin assessment completed on May 12, 2021, revealed that the resident had a RBKA (right below the knee amputation) surgical site and wound to toes. There was no further documentation of an assessment of the resident's surgical or vascular wounds. Review of Admission Documentation dated May 12, 2021 at 6:23 AM indicated that the resident had a surgical wound and had vascular wound(s). Further review of the documentation failed to reveal an assessment of the surgical site; location, color, drainage, swelling, staples, or sutures. Additionally, there was no assessment of the vascular wound(s). Review of Skin Observation Progress Note dated May 13, 2021 at 6:15 PM revealed that the resident's LBKA surgical site was not assessed, fresh amputation and not unwrapped and that he had a right heel diabetic ulcer. No further assessment of the resident's surgical or vascular wound(s) was available. Documentation dated May 18, 2021 at 2:22 AM revealed that the LBKA surgical site and staples and sutures present and that the wound was approximated, the resident had a right heel diabetic ulcer (no further information available) and a reddened sacrum. There is no further documentation in the resident's clinical record about the reddened sacrum. Interview with the Assistant Director of Nursing (ADON) on August 19, 2021, confirmed that there was no record or investigation of the resident's reddened sacrum. On May 18, 2021, a treatment was initiated to the resident's left below the knee amputation which consisted of cleansing the wound with normal saline solution, pat dry with 4x4's, apply ABD (highly absorbent sterile dressing) and wrap with kling every day shift. There was no documentation that the physician or wound care center ordered the treatment to the surgical site. On May 13, 2021, a treatment was initiated to the resident's right foot which consisted of cleansing the right foot with normal saline solution, pat dry with 4x4's, apply hydrogel (wound healing gel), place ABD and wrap with ace wrapping every evening shift. There was no documentation that the physician or wound care center ordered the treatment to the right food vascular wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of wound care consult dated May 26, 2021, revealed that the resident was suppose to be seen 1 week post op at wound care, facility did not schedule him at wound care, today left stump wound 21 staples were removed, sutures remain. According the to the consult, the resident stated that the facility was not monitoring his glucose (blood sugar) nor wiping his left stump (surgical site) with chloraprep daily. The resident was suppose to be scheduled with a prosthetics company ASAP for stump shrinker and prosthesis which did not occur. New orders written from wound care physician on May 26, 2021included chloraprep to left stump every day with a dry sterile dressing, keep leg straight no pressure to under knee and thigh or posterior stump, appointment with prosthetic company asap for stump shrinker and prosthesis, right foot wound packed with Silvadene and 2x2 packing daily, wash both sites with hibiclens 2 times a week (right foot and left stump), and keep glucose less than 200 at all times. Call Dr. {name} for glucose management. Review of the printed wound care consult report dated May 26, 2021, revealed that treatment to the right foot was Silvadene packing daily Monday through Friday and 1/4 strength dakins (a strong antiseptic that kills most forms of bacteria and viruses) packing daily on weekends. There was no evidence in the resident's clinical record that the wound care orders were clarified. Review of Resident CR1's medication administration record for May 2021, revealed an order dated May 26, 2021 to keep glucose <200 (less than) at all times, call Dr. {name} for glucose management every shift. There was no evidence that Resident CR1's physician was consulted for blood glucose management or that the resident's blood glucose was ever monitored up until his discharge on June 4, 2021. Interview with the ADON on August 19, 2021, at approximately 2:00 PM confirmed that there was no accurate documentation of the resident's wounds, physician orders were not implemented, and post-surgical wound care was not provided timely for Resident CR1. 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing Services 28 Pa. Code 211.5 (f)(g)(h) Clinical Records

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F 0692 Level of Harm - 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** 26142 Based on a review of clinical records and select facility policy and staff and resident interviews it was determined that the facility failed to timely assess a resident's weight, progressive weight loss and potential contributing factors to decreased oral intake, and implement applicable interventions to deter further weight loss, which resulted in an undesirable significant weight loss for one resident (Resident 6) and failed to timely monitor nutritional parameters to assure accurate nutritional assessment of one resident out of 20 residents (Resident CR1). Findings include: A review of the facility policy entitled Weight assessment and intervention adopted by the facility March 31, 2021 revealed The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. Procedures included: The nursing staff will measure resident weights on admission, the next day and weekly for 2 weeks, thereafter. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. Verbal notification must be confirmed in writing. The dietitian will respond within 24 hours of written notification. The dietitian will review the unit weight record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month--5% weight loss is significant; greater than 5% is severe. b. 3 months--7.5% weight loss is significant; greater than 7.5% is severe c. 6 months--10% weight loss is significant; greater than 10% is severe. The policy indicated that interventions to include: a. Resident choice and preferences b. Nutrition and hydration needs of the resident c. Functional factors that may inhibit independent eating d. Environmental factors that may inhibit appitite of desire to participate in meals e. chewing and swallowing abnormalities and the need for diet modifications (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A review of the clinical record revealed that Resident 6 was readmitted to the facility on [DATE], and had diagnoses including cerebral infarction (stroke), muscle weakness and cognitive communication deficit. A review of a resident belonging list (resident inventory record) dated March 22, 2017, (initial admitted d) revealed Resident 6 had upper and lower dentures. A review of a Dietary Note dated February 10, 2021 at 1:18 PM revealed that the resident had a weight change. Weight (2/5) 144.8 pounds, (1/7) 145.5 pounds,(11/2) 145.5 pounds, (8/3) 147.2 pounds. An insignificant weight loss of 0.5% (0.7 pounds), an insignificant weight gain of 6.9% (9.3 pounds) x 3 months, and an insignificant weight loss of 1.6% (2.4 pounds) x 6 months. Remains on regular diet, regular textures, thin liquids. Fair PO (by mouth) intake. Average recorded meal intake (2/3-2/9) 52% of meals. Ensure Enlive provided TID to supplement calorie and protein intake. No skin issues noted. Care plan updated. Will continue to follow. A nutritional data collection tool evaluation dated February 25, 2021, revealed that the resident weighed 144. 8 pounds (lb) on February 5, 2021. The evaluation indicated that the resident's ideal body weight (IBW) was approximately 145 pounds. The evaluation noted that the resident was independent with feeding, consumed 50% of his meals and received a regular diet. A quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated May 22, 2021 revealed that Resident 6 was severely, cognitively impaired, required set-up assistance for meals, weighed 145 pounds and received a regular consistency diet. A review of the resident's Weights and Vitals Summary report revealed that the resident's weight on the following dates was noted as: March 2, 2021, 145.3 pounds; April 5, 2021, 143.1 pounds; No documented weight for May 2021; June 3, 2021, 136.2 pounds, a 6.9# weight loss (4.82%); July 2, 2021, 131.6 pounds, 4.6# weight loss; August 1, 2021 127.3 pounds, 4.3# weight loss; Between March 2, 2021 and August 1, 2021, Resident 6 lost 18 pounds or 12.39 % over 5 months, which was a significant severe weight loss. A review of physician orders dated March 18, 2021, revealed that Remeron 7.5 mg, 1 tablet at bedtime for appitite stimulant was initiated. The Remeron was discontinued on July 21, 2021. Corresponding medication administration records (MAR) for March 2021 through July 2021 indicated that Resident 6 received the Remeron daily. A physician order dated March 31, 2021, was noted for the resident to receive a regular diet, regular texture with thin liquids. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Actual harm Residents Affected - Few	A physicians order dated May 18, 2021 was noted for the addition of the nutritional supplement Mighty shake (a liquid dietary supplement, protein and calorie dense) daily. A review of meal consumption records dated May 2021 revealed that the resident consumed 25% of breakfast and lunch on most days and 50% to 100% consumption of the dinner meal. There were multiple meals with no meal consumption recorded. A review of snack documentation for May 2021 revealed that the resident accepted a snack on most days, but multiple days lacked documentation of acceptance or refusal throughout the month with no documented consumption. A review of May 2021 Medication Admistration record revealed that the resident accepted the Mighty shake daily. Resident 6's diet was changed again, per a physician order dated May 30, 2021, to a regular diet, mechanical soft texture (A mechanical soft diet or soft food diet is a diet that involves only foods that are physically soft, with the goal of reducing or eliminating the need to chew the food) with thin liquids. However, there was no documentation in the resident's clinical record regarding the reason for Resident 6's diet change on May 30, 2021. There was no documented evidence that the resident was experiencing chewing or swallowing difficulties requiring a mechanically altered diet. A physicians order dated June 10, 2021 was noted for the addition of Ensure (liquid dietary supplement) 120 cc with medication pass, nursing to document amount consumed. A review of a social services note dated June 14, 2021, at 7:42 PM revealed Follow up, resident dentures are missing, Consult requested for speech eval. Request made for a dental appointment to be scheduled. A review of meal consumption records dated June 2021 revealed that the resident consumed 0 % of breakfast and lunch and dinner from June 1, 2021 through June 16, 2021, and 0 % consumption or refusal of the dinner meal from June 17, 2021 to June 30, 2021. There were multiple meals with no meal consumption recorded. A review of snack documentation for June 2021 revealed that the resident accepted a snack on most days, but several days lacked documentation of acceptance or refusal. A review of June 2021 Medication Admistration record revealed that the resident accepted the Mighty Shake daily. Further review of the June 2021 MAR revealed from June 10, 2021, to the end of the month of June 2021, the resident consumed from 0%-100% of the Ensure (liquid dietary supplement) consumed daily. A review of a facility rehabilitation services screening request to speech therapy dated June 15, 2021, revealed Resident reported with missing dentures. Staff reports resident eats what he wants, but never eats a lot. Resident resistant to staff intervention in room. Staff reports they give him Ensure when he does not eat his meal. Staff interviewed reported resident will not eat pureed foods. Resident's diet level down graded to mechanical soft when dentures first misplaced. Noted recommendations, as resident refused to allow speech therapy to interview or observe during by mouth intake. No speech services at this time. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A review of a facility rehabilitation services screening request to speech therapy dated June 24, 2021 revealed resident refused to work with speech therapy, gibberish language with clear gestures to leave the room. Staff reports resident refuses solids until he receives his dentures. resident accepts puddings and ice creams. Comes to the desk for nutritional drinks. Recommending nutritional drinks and ice cream on all meal trays. A review of snack documentation for July 2021 revealed accepted on most days with multiple days with no documented acceptance or refusal. A review of July 2021 medication Admistration record revealed that the resident consumed Mighty Shake liquid supplement daily and 100 cc of Ensure (liquid dietary supplement) on most days. A review of meal consumption records dated July 2021 revealed that the resident consumed 0 % of breakfast, but six days lacked documentation of meal consumption, 0% at lunch, with no documented consumption on 7 days and and 5-25 %, 1-50%, and 1-75% consumption of the dinner meal. On four days the amount of dinner consumed was not recorded. The next dietary/nutrition note was dated August 11, 2021 4:33 PM and revealed and noted that the resident had a significant weight loss of 12% in six months and now weighted 127.3 lbs with a BMI (body mass index-body mass index is a value derived from the mass and height of a person) of 20.5 (In older adults it is often better to have a BMI between 25 and 27, rather than under 25. If you are older than 65, for example, a slightly higher BMI may help protect you from thinning of the bones). The resident's ideal body weight was noted as 142 lbs. The entry noted that some weight loss anticipated with aging process as body composition changes, goal is to preserve lean muscle mass and promote weight stability. The entry noted that the resident was able to feed self, usual intake at meals is poor. Supplements in place to increase kcal/protein density of diet with overall good acceptance. It was also noted that a Trial HS snack-monitor acceptance. Continue supplements to enhance intake as well. Tolerating diet as ordered with no chewing/swallowing difficulty noted. Liberalized diet remains appropriate to optimize intake. Will recommend weekly weights to closely monitor trend and reassess need for additional intervention as indicated. The nutrition note dated August 11, 2021, indicated that the resident had no chewing issues. However the resident had been missing his upper and lower dentures since at least June 14, 2021, per social service documentation. This resident's upper and lower dentures were noted to be missing at the time of the nutrition note. The resident's intake at meals continued to decline and/or fluctuate. Current physicians orders dated August 13, 2021, were noted for the resident to receive a regular diet, soft & bite Sized texture, thin Liquids consistency At the time of the survey ending August 19. 2021, there was no additional nutritional/dietary documention in the resident's clinical record. At the time of the survey ending August 19, 2021, the resident remained without dentures. A review of meal consumption records dated August 1, 2021, through August 19, 2021, revealed that the resident ate breakfast on only two days during the time period, ate lunch on one day, with the remaining days documented as 0% or refused. There were multiple meals with no consumption percentages documented. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	At the dinner meal the resident consumed only five meals, one at 25%, one meal at 50% and the remaining meals as 0% or refused. There were multiple meals with no documented consumption. A review of snack documentation for August 2021 revealed that the resident accepted a snack on 5 days, with the additional days refused up to August 19, 2021. A review of August 2021 medication admistration record that the resident consumed the Mighty Shake daily and his intake of the Ensure ranged from 25 cs to 240 cs. There was no documented evidence in the resident's clinical record at the time of the survey ending August 19, 2021, that the facility had identified and correlated the lack of the resident's upper and lower dentures with the resident's declining intake at meals beginning May 2021, through the time of the survey. A review of a dietary notes revealed no documented evidence in the resident's clinical record that the dietitian had addressed the resident's decreased intake by obtaining the resident's food preferences, as per facility policy, and had addressed the resident's missing dentures in relationship to diet consistency and food preferences. There was no documented evidence that the facility had responded to the resident's significant weight loss, identified on August 1, 2021, with additional interventions until August 11, 2021. An observation of the resident on August 19, 2021, at approximately 11:45 AM revealed that the resident was lying in bed. The resident's breakfast tray was on his overbed table, next to the bed and was uneaten. Observation of the meal revealed that the resident had been served an egg omelet, a round sausage patty, cut up in four equal pieces, each piece of the patty measured approximately 1.5 inches x 1.5 inches x 2 inches. A review of Resident 6's breakfast tray ticket (a paper form with the residents diet, diet texture along with the breakfast food items for this resident for meals) for August 19, 2021, breakfast meal revealed Diet: Regular, Diet, soft and bite sized. The noted food items included a diced sausage patty. During an interview at the time of the observation, Resident 6's speech was garbled, but when asked about his breakfast the resident stated I'm hungry. This surveyor then asked him if he had difficulty chewing his food and the resident said yes and pointed his fingers to the inside of his mouth multiple times, showing that he was edentulous (lacking teeth) Interview with the interim director of nursing on August 19, 2021, failed to provide documented evidence that the facility had timely acted upon the resident's missing dentures, resulting in decreased ability to chew, declining oral intake and significant progressive weight loss. The facility did not timely address the resident's severe weight loss identified on August 1, 2021. The facility added liquid nutritional supplements, but failed to identify and address the resident's underlying contributing factor to the weight loss and identify preferences for meals consistent with his chewing abilities until the resident's dentures are replaced. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident CR1's clinical record revealed admission to the facility on [DATE], with diagnoses that included left below the knee amputation (completed on May 6, 2021), bacteremia (blood infection), and abscess of the right foot. A review of the resident's Weights and Vitals Summary report revealed that the resident's weight on the following dates was noted as: May 12, 2021 - 163.0 pounds; May 18, 2021 - 138.3 pounds; May 18, 2021 - 139.5 pounds (re-weight); a 23.5 pound/ 14.4% weight loss in 6 days. Review of Resident CR1's admission assessment dated [DATE], revealed that the resident was 70 inches tall and 163 pounds. There was no documented evidence that a re-weight on admission was obtained as outlined in the facility's weight policy. Review of Resident CR1's hospital discharge revealed that the resident weighed 163 pounds on May 2, 2021, four days prior to the surgical amputation of his left leg below the knee. Review of Dietary Note dated May 25, 2021, at 10:30 AM indicated that the weight decrease/loss since admission may be possibly related to the resident's BKA (below the knee amputation) and currently suffering from diarrhea. Interview with the Assistant Director of Nursing on August 19, 2021, at approximately 2:00 PM confirmed that the facility failed to obtain an accurate admission weight on Resident CR1 to assure an accurate assessment of the resident's nutrition and hydration needs and failed to implement the facility's weight policy. Refer F791, F805 483.25 Nutrition/Hydration Status Maintenance Previously cited 101/20 28 Pa Code 211.6(d) Dietary services Previously cited 10/1/20, 10/15/20, 11/24/20, 1/19/21, 5/27/21 28 Pa. Code 211.12(a)(c) Nursing services. Previously cited 8/23/19, 11/24/20, 1/19/21, 3/26/21, 5/27/21 28 Pa. Code 211.12(d)(3) Nursing services. Previously cited 8/23/19, 1/19/21, 3/26/21, 4/21/21, 5/27/21 28 Pa. Code 211.12(d)(5) Nursing services. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Previously cited 8/23/19, 10/1/20, 11/24/20, 1/19/21, 3/26/21, 4/21/21, 5/27/21

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 13456 Based on clinical record review and interview with staff, it was determined that physician progress notes failed to demonstrate that the physician had reviewed the resident's total program of care at each visit and that the progress notes accurately reflected the status of three of 20 residents reviewed (Resident CR1) Findings include A review of Resident 1's clinical record revealed nursing documentation dated July 6, 2021, which indicated that the resident presented with a bruise on the left side of his face, which may have been have been the result of a fall. Nursing documentation of July 6, 2021, also indicated that the resident had a wound to his left thigh. On July 13, 2021, the resident was found on the floor and observed with bruising of his right arm, upper back and a skin tear to his left elbow. On July 14, 2021, the resident was noted as confused and refused his medications according to nursing documentation. On July 26, 2021, the resident's left hand was swollen and a X-ray was ordered, which was negative for fracture, but an antibiotic was ordered. Nursing documentation of July 29, 2021, indicated that the resident had a bloated stomach and the attending physician was made aware. Documentation of July 30, 202 indicate the resident's abdomen remained slightly distended. A review of the clinical record of Resident 1 revealed that the attending physician progress notes were written on a scrap sheet of white paper with dates from April 7, 2021 through August 4, 2021. The August 4, 2021, progress notes read lungs clear, out of bed, cellulitis to hand better. There was no indication in this physician progress note that the physician was aware of the resident's current status and condition as described in nursing notes and had assessed/addressed these concerns and issues at the time of the visit. A review of Resident 20's clinical record revealed nursing documentation dated July 1, 2021, which indicated that the resident bumped his head and was to be sent to the hospital for a pea sized lump on the left side of his head. However, the resident refused to be transferred to the hospital. Nursing documentation indicated that his attending physician could not be reached and the medical director made the recommendation for the resident to be transferred. A review of the resident's physician progress notes written by the attending physician dated July 2, 2021, noted solely diarrhea post eating, discontinue Moo milk. The physician progress note did not address the lump on the resident's head. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing documention dated August 1, 2021, indicated that the resident was difficult to arouse and he was transferred to the hospital and returned later in the day with a recommendation to begin Hospice services. A physician progress by the attending physician dated August 4, 2021 indicated lungs, clear, bradycardia, wants to see cardiology, Miralax Monday- Wednesday-Friday, Ice cream with dinner. The physician progress note did not address the resident's recent change in condition , hospital transfer and recommendation for Hospice care. The physician progress notes did not reflect the changes in the resident's condition from month to month. A review of Resident 21's clinical record revealed nursing documentation dated April 13, 2021, which indicated that the resident had a significant weight loss of 15% in three months. Nursing documentation of April 28, 2021, indicated that the resident had multiple deep tissue injuries to his heels and sacrum and two of the wounds (wound #2 and wound #3) were worsening. A review of the attending physician's progress notes dated May 1, 2021, revealed lungs clear, back healing, neuro-stable. The physician progress notes dated June 4, 2021, read lungs clear, out of bed, sugars good. The physician did not address Resident 21's worsening pressure sores in his progress note. The physician also indicated that the resident's sugars were good. However, the resident only had an order dated March 18, 2021, for blood glucose as needed and facility nursing staff had not documented any glucose levels obtained from March 2021 until the progress note date of June 4, 2021. The aforementioned physician progress notes were not specific to the resident's current status at the time of the documentation. The progress notes were all written by the same attending physician. Interview with the interim director of nursing on August 19, 2021, at 4:00 PM confirmed the documentation was not specific to the residents' current status at the time of each physician progress note entry. 28 Pa. Code 211.2 (a) Physician services 28 Pa. Code 211.5 (f)(g)(h) Clinical records.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 13456 Based on observations, review of clinical records and select facility policy and staff interview it was determined the facility failed to implement pharmacy procedures for the timely disposition of unused/outdated medications for six of six discharged residents reviewed. (Resident 22, CR3, CR4, CR5, CR6 AND CR7). Findings include: A review of the facility policy entitled Storage of Medications dated [DATE] indicated that drugs and biologicals used in the facility are stored in marked compartments under proper temperature, light, and humidity controls and only one person authorized to prepare and administer medications have access to the locked medications. Compartments included but not limited to drawers, cabinets, rooms, refrigerators carts and boxes containing drugs and biologicals are locked when not in use. A review of the pharmacy policy entitled Discontinued Medications indicates discontinued medications must be destroyed or returned to the issuing pharmacy in accordance with established policies which state that medication supplied in sealed unopened containers may be returned to the issuing pharmacy for disposition provided that all such medications are identified by lot control number and the by the prescribing pharmacist and a registered nurse employed by the facility signing separate log that lists the residents name, the name strength, prescription number if applicable and amount of the medication returned and the date the medication was returned. The facility shall utilize a medication disposition record which would contain the residents name, the date the medication was disposed, the name and strength of the medication, the name of the dispensing pharmacy, the quantity disposed method of disposition, reason for disposition, and signature of the witness. Completed medication disposition records shall be kept on file in the facility for at least two years or as mandated by the state law governing the retention and storage of such records. Facility staff shall contact the provider pharmacy if they are unsure of proper disposal methods for medication. Observation on [DATE], while in the facility conference room at approximately 5:25 PM revealed that during pest control service earlier that day, a cupboard in the room was left open. Closer observation revealed that this cupboard contained multiple bags containing prefilled heparin (Heparin is a medication used in an intravenous line to prevent the formation of blood clots) syringes and pre-filled saline syringes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Mulitple plastic bags containing were observer containing pre-filled heparin syringes dispensed for Residents' 22, CR3, CR4, CR5, CR6 AND CR7. Five of the six bags of prefilled heparin syringes belonged to residents who had been discharged from the facility. Resident 22, remained in the facility at the time of the observation, but it was unclear why the medication was stored in this conference room. There were also multiple bags of re-filled saline syringes, some of which were expired. There were one bag of heparin pre-filled syringes with no resident names and two bags of pre-filled saline with no resident names, which had expiration dates of February 2021. There were approximately 16 sealed bags of pre-filled syringes with multiple syringes in each bag. During the exit conference with the facility on [DATE], the interim director of nursing stated that the pharmaceuticals should not be stored in this room they should have been destroyed or returned to 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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **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 promptly, within 3 days, refer a resident with lost dentures for dental services and ensure that timely and sufficient measures were taken to assure that the resident could still adequately eat while awaiting dental services for one resident out one sampled with missing dentures (Resident 6). Findings include: At the time of the survey ending August 19, 2021, the facility did not have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility. A review of the clinical record revealed that Resident 6 was readmitted to the facility on [DATE] with diagnoses to included cerebral infarction (stroke), Muscle weakness and Cognitive communication deficit. A quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated May 22, 2021 revealed that Resident 6 was severely, cognitively impaired, required set up assistance for meals, weighed 145 pounds and received a regular consistency diet. A review of a resident belonging list (resident inventory record) dated March 22, 2017, (original admission) revealed that Resident 6 had upper and lower dentures. A review of physicians orders dated March 31, 2021, revealed that the resident was prescribed a regular diet, regular texture with thin liquids. Resident 6's diet was changed on May 30, 2021, per a physician order for a regular diet, mechanical soft texture (A mechanical soft diet or soft food diet is a diet that involves only foods that are physically soft, with the goal of reducing or eliminating the need to chew the food) with thin liquids. There was no documentation in the resident's clinical record regarding the reason for Resident 6's diet change on May 30, 2021. A review of a social services note dated June 14, 2021 at 7:42 PM revealed Follow up, resident dentures are missing, Consult requested for speech eval. Request made for a dental appointment to be scheduled. At the time of the survey ending August 19, 2021, it could not be determined when the facility first identified or received the report of the resident's missing dentures, although according to the physician order of May 30, 2021, and a speech therapy screen dated June 15, 2021, it was estimated that the loss occurred on or around May 30, 2021. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility rehabilitation services screening request to speech therapy dated June 15, 2021 revealed Resident reported with missing dentures. Staff reports resident eats what he wants, but never eats a lot. Resident resistant to staff intervention in room. Staff reports they give him Ensure when he does not eat his meal. Staff interviewed reported resident will not eat pureed foods. Resident's diet level down graded to mechanical soft when dentures first misplaced (diet changed per physician orders on May 30, 2021). Noted recommendations as resident refused to allow speech therapy to interview or observe during by mouth intake. No speech services at this time. A review of a facility rehabilitation services screening request to speech therapy dated June 24, 2021 revealed Resident 6 refused to work with speech therapy, gibberish language with clear gestures to leave the room. Staff reports resident refuses solids until he receives his dentures. resident accepts puddings and ice creams. Comes to the desk for nutritional drinks. Recommending nutritional drinks and ice cream on all meal trays. There was no documented evidence at the time of the survey ending August 19, 2021, as to the specific date that Resident 6's dentures went missing. There was no additional documentation in the clinical record regarding his dentures or dental services at the time of the survey ending August 19, 2021. There was no documented evidence at the time of the survey of any policy, procedure or protocol regarding resident dentures, care and services, storage, investigation into missing dentures or loss or damage to a residents dentures. During an interview August 19, 2021 at approximately 3 PM, the interim Director of Nursing confirmed that there was no facility policy regarding resident dentures and that Resident 6's has been without dentures for an extended period of time. Cross refer F692 and F 805 28 Pa Code 211.12 (a)(d)(1)(3)(5) Nursing services 28 Pa Code 211.15 (a) Dental services

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	395421	A. Building B. Wing	08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Brook Rehabilitation and Healthcare Center	801 East 16th Street Berwick, PA 18603

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observation and review of clinical records and staff interview, it was determined that the facility failed to ensure that food was served in a form to meet the individual needs of two of 20 residents (Resident 6, 13). Findings include: A review of the clinical record revealed that Resident 6 was readmitted to the facility on [DATE], with diagnoses to included cerebral infarction (stroke), muscle weakness and cognitive communication deficit. A quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated May 22, 2021, revealed that Resident 6 was severely, cognitively impaired, required set up assistance for meals, weighed 145 pounds and received a regular consistency diet. A review of a resident's belonging list (resident inventory record) dated March 22, 2017, (from the resident's initial admission) revealed Resident 6 had upper and lower dentures upon admission. A review of current physician orders dated August 13, 2021, revealed that the resident was prescribed a Regular diet, Soft & Bite Sized texture, Thin Liquids consistency. An observation on August 19, 2021, at approximately 11:45 AM, Resident 6 was observed lying in bed. The resident's breakfast tray was observed on his overbed table, next to the bed. The resident's meal was uneaten. The meal included an egg omelet and a round sausage patty, cut up into four equal pieces, each piece of the patty measured approximately 1.5 inches x 1.5 inches x 2 inches. A review of Resident 6's breakfast tray ticket (a paper form with the residents diet, diet texture along with the breakfast food items for this resident for meals) for the August 19, 2021, breakfast meal revealed that the ticket noted Diet: Regular, Diet, soft and bite sized. The tray ticked identified that the resident should be served a diced sausage patty. A review of a facility dietary form entitled Soft and bite sized consistency diet (from the facility diet manual) revealed the following: 1. Description, soft and bite sized (formerly known as dysphagia (difficulty swallowing)) is designed for individuals with mild oral and or pharyngeal phase dysphagia. This diet follows the regular diet planned and consists of nearly regular textures with the exception of very hard, sticky or crunchy foods. Foods need to be moist and should be in bite-sized pieces at the oral phase of the swallow. All food pieces are to be less than or equal to 1/2 inch in size. All foods to be served may be audited with standardized testing procedures including fork/spoon pressure test. The procedure included, for protein food items, chop applicable items to 1/2 inch pieces immediately before service. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview August 19, 2021 at approximately 2 PM, Employee 1 (registered dietitian RD) confirmed that the sausage patty served to Resident 6 was not cut into the correct portion size according to the diet manual and the verified that the sausage patty should have been diced into smaller pieces as noted on the resident's tray ticket. Observation during the lunch meal revealed Resident 13 seated at a table in the North dining room. Resident 13's meal was in front of her. A review of Resident 13's meal ticket indicated that Resident 13 was to receive a nectar-thickened coffee (consistency has slightly more body than coffee but can still pour easily and is prescribed for difficulty swallowing thin liquids) with her meal. Further observation of the resident's meal revealed the nectar-thickened coffee was not provided as planned. Interview with the dietary manager on August 19, 2021 at 11:30 AM confirmed that residents are to receive the food items, in the form, as indicated on their individual tray ticket to meet their individualized needs. Refer F692 28 Pa. Code 211.6 (c) Dietary Services.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 13456 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide adaptive dining equipment as ordered for one 16 residents reviewed (Resident 14). Findings include: A review of resident clinical records revealed that Resident 14 had a current physician's order dated August 18, 2021, for a Nosey cup (adapted drinking cup with a u-shaped cut out on one side which allows the user to tilt the cup for drinking without bending the neck or tilting the head) for all meals for beverages. Observation of the lunch meal in the North dining room on August 19, 2021, at approximately 11:30 AM revealed that Resident 14 did not receive a Nosey cup with her lunch meal. This observation was confirmed by Employee 5 (speech therapist) at the time. Interview with the dietary manager on August 19, 2021, at 1:00 PM confirmed that the Nosey cup should have been provided on the resident's tray and was not present at this meal. 28 Pa. Code 211.12 (a)(d)(3)(5) Nursing services. 28 Pa. Code 211.6 (c)(d) Dietary services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 13456 Based on observation 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 in the food and nutrition services department. 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). An observation of the food and nutrition services department on August 19, 2021 at 12:30 PM revealed the following concerns: There was an approximate 4-inch by 4-inch missing drain cover next to the ice machine. There were 4 cases of nutritional shakes in the walk-in cooler, which were not labeled with a thaw date. Review of the manufacturer's label indicated to use the product within 14 days of thawing. Interview with the dietary manager at this time confirmed there were no thaw dates placed on the nutritional shakes. The facility's walk-in freezer was observed to be out of service. Interview with the dietary manager confirmed that the freezer had not been working since Monday August 16, 2021. The part to repair the freezer was to arrive Friday August 20, 2021. The facility was unable to obtain a freezer truck or temporary replacement freezer. Further observation of the non-functional walk-in freezer revealed cases of peas, Italian blend vegetables, and carrots all labeled to keep frozen. Interview with the dietary manager at this time confirmed that the kitchen was to be maintained in a sanitary manner and that food items were to be properly stored and dated. 483.60(i)(1)(2) Food Procurement, Store/Prepare/Serve-Sanitary Continuing deficiency from survey ending 6/29/21 28 Pa. Code 207.2(a) Administrator's responsibility 28 Pa Code 211.6(c) Dietary services

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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 a review of the facility's plan of correction for the deficiencies cited during the survey ending June 29, 2021, clinical records and outcome of the activities of the facility's quality assurance plan, observations and staff interviews it was determined that the facility failed to develop and implement an effective quality assurance plan to correct and prevent continued quality deficiencies related to food and nutrition services. Findings included: A review of the statement of deficiencies cited during the survey ending June 29, 2021, revealed that the facility developed a plan of correction that included a quality assurance monitoring plan to assure that corrections to the quality deficiencies were sustained. This plan was to be completed by August 17, 2021. In response to the deficiency cited for food served in a form to meet individual resident needs the facility's plan of correction indicated that: 2. Similar residents will be resident diets will be reviewed by the Dietary Manager, Registered Dietician, and Speech therapist to validate the proper textures meet the resident's current needs and tray tickets reflect the current physician's orders. Moving forward, Dietary Managers/designee to random tray line audit to ensure residents are being served appropriate diets per tray ticket. 3. Dietary and Nursing staff will be educated by the Dietary Manager/Registered Dietician/Director of Nursing /Designee on the diets and textures served at the facility and provide examples appropriate food and foods to avoid for mechanical diets. 4. The Dietary Manager/Registered Dietician/Designee will audit random meals, on varied days of the week daily x 2 weeks, weekly x 2 weeks and monthly x 3 months. The manager assigned to the dining room will monitor 10 random resident meals per week x 2 weeks, weekly x 2 weeks then monthly x 2 months to validate foods served match the tray ticket. Audit results will be reported to the Quality Assurance and Process Improvement Committee for further review and recommendation. However, during this revisit survey ending August 19, 2021, it was found that the facility failed to provide food in a form planned for two out of 20 residents reviewed (Resident 6, 13). The facility's quality assurance committee failed to develop and implement effective corrective actions plans to correct, and sustain correction of these quality deficiencies, and prevent recurrence of deficient practice, failing to improve the delivery of quality care and services to residents. Refer F805 (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.6 (c)(d) Dietary services 28 Pa. Code 211.12(c) Nursing Services 28 Pa. Code 201.18(e)(1) Management

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observation and staff interview, it was determined the facility failed to ensure staff implemented infection control practices to prevent the potential spread of infection on two of two resident units observed (Spruce and North). Findings include: An observation August 19, 2021, at approximately 10 AM Employee 3 (nurse aide) was passing ice water to residents outside room [ROOM NUMBER]. The uncovered ice chest was on a rolling cart. The ice scoop was observed to be within the ice in the ice chest. Employee 3 passed ice by scooping the ice from the chest using her ungloved hand and then repeatedly returning the scoop to the chest with ungloved hands, to multiple resident rooms on this hallway, with the cover off the chest and the ice scoop remaining in the ice. The cover to the chest was observed on the second shelf of the cart during the pass. During an interview at the time of the observation, Employee 3 stated that the top of the ice chest was broken and placed on the second shelf of the cart during her water pass then placed back on the chest. She confirmed thart she routinely leaves the ice scoop in the ice, and retrieves it as needed, until the pass is complete. An observation on August 19, 2021, at approximately 10:15 AM in resident room [ROOM NUMBER] W, there was an uncovered bed pan and a basin with toiletries (shampoo, conditioner, powder, skin lotion etc) stored directly on the floor at the end of the resident bed. An observation August 19, 2021 at approximately 10:10 AM, in the Spruce hallway resident pantry, revealed that the the stainless steel sides of the ice machine were stained with liquid stains and splash marks. The drainage area, as well as, the grate (on the front of the machine were dirty with discolored spotting. There was no air gap observed (an area approximately 1.5 to 2 inches) created between the matching drip pipe and the actual drain to create an area so no bacteria can travel from the drain back into the ice machine) with the pipe connected directly to the floor drain grate, which was suspended into the floor drain. During an interview August 19, 2021 at approximately 3 pm, Employee 2 (maintenance) confirmed that there was no air gap on the ice machine in the Spruce hallway resident pantry. An observation conducted at 8:10 AM on the North unit revealed an unidentified staff member dragging a plastic bag of soiled linens from Resident room [ROOM NUMBER], directly across the hallway floor to the dirty utility room. This bag of soiled linen was placed on the floor in the soiled utility room, although there were large containers available for placement of the bag of soiled linen. During an interview August 19, 2021 at approximately 3:15 PM, the interim Director of Nursing confirmed that infection control protocols were followed during the above observations. 28 Pa Code 212.12 (a)(c)(d)(1)(3)(5) Nursing Services