STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395491	A. Building B. Wing	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Valley Manor, Inc	4227 Manor Drive Stroudsburg, PA 18360

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 26142 Based on observation and resident and staff interview, it was revealed that the facility failed to reasonably accommodate one resident's need for call bell accessibility out of 20 sampled (Resident 27). Findings include: An observation on the COVID unit on October 20, 2022 at 10 AM revealed Resident 27 was in bed in her room. However, the resident's call bell was observed on the floor out of her reach. During an interview at the time of the observation, Resident 27 stated that she does use the fall bell to alert nursing staff to her needs and confirmed that her call bell was not accessible. During an interview October 20, 2022 at 2 P.M., the Director of Nursing confirmed that call bells should be within resident reach. 28 Pa. Code 201.29(j) Resident rights

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and staff interview, it was determined that the facility failed notify the resident's representative, of a significant weight loss, for one resident out of 20 sampled residents (Resident 37). Findings include: A review of the clinical record revealed that Resident 37 was admitted to the facility on [DATE], with diagnoses to include schizophrenia. A quarterly Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated August 18, 2022, indicated that the resident was cognitively intact Resident 37's clinical record reflected a primary representative (responsible party and emergency contact #1) as a family member (Daughter). The resident's weight record revealed the following recorded weights: 4/27/2022 11:02 234.4 Lbs 5/2/2022 11:33 234.2 Lbs 5/9/2022 10:58 234.0 Lbs 5/16/2022 13:25 234.2 Lbs 6/2/2022 08:09 202.0 Lbs 6/3/2022 09:48 202.0 Lbs 32.2 pounds, 13.68% significant weight loss A Dietary Note dated June 3, 2022, indicated a weight loss had occurred and interventions were implemented. There was no documented evidence that the facility had notified the resident's resident representative of the significant unplanned weight loss noted on June 3, 2022. Interview with the Nursing Home Administrator (NHA) on October 20, 2022, at approximately 12:05 p.m. confirmed there was no documentation that Resident 37's resident representative was notified of the significant unplanned weight loss. 28 Pa Code 211.12 (a)(c)(d)(3)(5) Nursing services 28 Pa Code 201.29(a)(l)(2) Resident rights

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on observations and staff interview, it was determined that the facility failed to provide housekeeping services necessary to maintain a clean resident environment on two out three nursing units (A1 and A2) Findings include: Observations of the A1 resident unit on October 18, 2022, at 9:50 a.m. revealed dirt and debris buildup on the floor throughout the unit along the walls and around the nurses station. Deep gouges were observed in the wall next to the elevators. The handrails throughout the unit were chipped along the edges. The molding along the bottom walls throughout A1 Unit were bent and damaged. Observations in the A1 unit lounge revealed dirt and debris buildup on the floor against all walls of the lounge. Observation revealed that there were gouges in the walls, the molding along the walls was bent inwards and one area of the wall the baseboard molding was cracked. Follow up observations of these same areas at 11:05 a.m. on October 19, 2022, revealed that they remained in the same condition. During a tour of the resident unit A2 on October 18, 2022, at 9:47 AM, outside of the resident's shower room, along the bottom of the wall there was a hole in the drywall. Upon entering the resident shower room, there were several damaged tiles observed along the threshold. There was a hole in the drywall at the bottom of the wall that was adjacent to the clean utility room. Inside of resident room [ROOM NUMBER], the wall underneath the overbed light was damaged and covered over with plaster-like material. The curtain that divided room [ROOM NUMBER] was observed to be partially detached from the ceiling. Observation of the ceiling that was outside of room [ROOM NUMBER] revealed that tiles had been removed with the plenum space (space above the drop ceiling) with wires exposed. Inside of the resident lounge area there was a surgical mask on the floor. Interview with the Administrator on October 20, 2022, at 2:45 p.m. confirmed that the facility failed to provide timely housekeeping services to maintain a clean resident environment. 28 Pa. Code 207.2 (a) Administrator's Responsibility.

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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. 39929 Based on a review of the facility's abuse policy and employee personnel files and staff interviews, it was determined that the facility failed to implement their established procedures for screening five of five employees for employment (Employees 4, 5, 6, 7, and 8) Findings include: A review of the facility's Resident Abuse policy last revised by the facility August 2018, revealed procedures for screening potential employees that included to screen all potential employees for any previous history of abuse, neglect, or mistreating of residents as defined by applicable requirements. All employees undergo a criminal background check and pre-employment drug testing. Potential employees will provide at least 3 references, both professional and personal. Review of employee personnel files revealed that Employee 4 (RNAC) was hired October 3, 2022, and there was no documented evidence that reference checks from previous employers were obtained prior to the staff's start of employment. Review of employee personnel files revealed that Employee 5 (Maintenance) was hired October 3, 2022, and there was no documented evidence that reference checks from previous employers were obtained prior to the staff's start date. Review of employee personnel files revealed that Employee 6 (Dietary) was hired October 17, 2022, and there was no documented evidence that reference checks from previous employers were obtained prior to the staff's start date. Review of employee personnel files revealed that Employee 7 (Screener) was hired September 19, 2022, and there was no documented evidence that reference checks from previous employers were obtained prior to the staff's start date. Review of employee personnel files revealed that Employee 8 (Activities) was hired August 4, 2022, and there was no documented evidence that reference checks from previous employers were obtained prior to the staff's start date. Interview with the Director of Human Resources on October 21, 2022, at 11:15 a.m. verified that the facility was unable to provide evidence that a previous employer was contacted according to the facility's screening procedures outlined in the Resident Abuse policy for Employees 4, 5, 6, 7, and 8. 28 Pa Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a)(c)(d) Resident rights 28 Pa. Code 205.19 Personnel policies and procedures

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of clinical records and select incident reports and staff interview it was determined that the facility failed to utilize safe technique and/or sufficient staff assistance with bed mobility and effectively secure safety devices to prevent a fall from bed resulting in serious injury, a fracture, for one resident out of 20 sampled residents (Resident 6). Findings include: A review of the clinical record revealed that Resident 6 was admitted to the facility on [DATE], with diagnoses of dementia with behavioral disturbances [Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia that include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances.] and history of falls. The resident had current physician's orders, initially dated August 21, 2019, for the placement of bed bolsters on the resident's bed for positioning. A review of a quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment completed at specific times to identify resident care needs) dated April 26, 2022, indicated that Resident 6 had severe cognitive impairment and required extensive assistance of two plus staff for bed mobility, transfers, toileting, dressing, and with personal hygiene. Resident 6's care plan initiated on September 13, 2019, revealed that the resident was at risk for falls related to confusion, deconditioning, gait/balance problems, incontinence, poor comprehension/communication, and unawareness of safety needs. The resident's goal was not to sustain serious injury through the review date related to falls. Planned interventions were the use of bilateral fall mats with low bed, and bed alarms. The resident's care plan also included the approach of using lift sheets and assist of two staff when turning the resident in bed every two hours. The resident' bedside Kardex (a summary of the care needs and level of staff assistance required for the care of the resident) in effect on May 30, 2022, revealed that Resident 6 required a lift sheet and assist of two staff when turning resident in bed. A facility investigation report dated May 30, 2022, at 10:00 AM, revealed that Employee 1, a RN, was notified that Resident 6 had a witnessed fall from bed while Employee 2, an agency nurse aide, was providing care to the resident. The investigation indicated that while Employee 2 was changing Resident 6 the resident rolled out of bed onto floor. Employee 2 was yelling for help and when Employee 1 entered the resident's room, the resident was found face down on the floor with blood present, and with her right arm underneath her body, and liquid stool being eliminated from the resident. The resident was rolled onto her back as to get her face off the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Further review of the investigation report revealed that the resident was assessed for injury and was found to have had a hematoma to right forehead that measured 9.0 cm x 8.0 cm with bleeding and a small laceration to right elbow that measured 2.0 cm x 0.5 cm. Resident 6's right collar bone was protruding and bulging. Wound care was given, her forehead cleaned with absorbent dressing applied, attending physician was notified with orders given to transfer Resident 6 to the emergency department for treatment and evaluation. Review of a nursing progress dated May 30, 2022, at 9:28 PM, revealed that Resident 6 returned to facility at approximately 4:00 PM, with a fractured clavicle and a laceration to right side of head that was actively bleeding upon LPN/RN assessment of return. Additionally, there was evidence of increased pain due to Resident 6 noted to have been wincing with facial grimacing upon movement with new orders given by the attending physician for stronger pain medication. A review of a Fall Investigation Statement completed by Employee 2 and dated May 29, 2022, (fall was documented to have occurred on May 30, 2022, and no time indicated) revealed that Employee 2 stated that I was giving care and when turned, the bed bumper fell to the ground, and she fell along with it. Employee 2's statement indicated that the fall could have been prevented if the bed bumper was secured. A fall investigation statement that was completed by Employee 3, a LPN, dated May 30, 2022 (no time specified), revealed that found the resident in the prone position (lying on your stomach, face down), upon assessment a hematoma to the right forehead, ice pack applied, abrasion (scrape) to the right elbow. Employee 3 noted that the fall could have been prevented if two staff members were used with positioning. Review of an undated facility policy entitled Positioning, Bed indicated to place any positioning devises per order, monitor for proper use and placement. During an interview October 20, 2022, at 10:25 AM, the Director of Nursing (DON) stated that if the resident required two people for care that she (Resident 6) would have had an order for two people for care at all times, and that it would have been care planned. The DON stated that because the resident weighed less than 100 pounds, the resident could be safely turned with one person, despite the MDS assessment, care plan and Kardex indicating that the resident required the assistance of two people for bed mobility. The DON also stated that the bed bolster became disconnected from the bed frame and that the weight of the resident against the bolster caused the to fall from bed. The facility failed to ensure that planned safety devices were securely applied and sufficient staff assistance were used to prevent a fall with serious injury to this resident. The facility failed to ensure two staff were utilized for bed mobility and while receiving care in bed and that these staff members used safe technique to prevent a resident's fall from bed that resulted in a fracture. Employee 2 rolled Resident 6 away from her without another staff member on the opposite side of the bed. Interview with the DON on October 20, 2022, at 10:45 AM, confirmed that the facility failed to safely provide care and verified that the facility had not identified or addressed the failure to provide two-person assistance with the resident's bed mobility as assessed and care planned to prevent the fall from bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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 observations, clinical record review, and staff interview it was determined that the facility failed to consistently provide an enteral feeding as ordered to meet a resident's nutrition and hydration needs to prevent significant weight loss, signs of dehydration and promote satiety and to ensure the resident receives sufficient fluid and feeding formula to maintain proper hydration and health for one resident out of two sampled receiving assisted nutrition and hydration (Resident 10). Findings include: Clinical record review revealed that Resident 10 was admitted to the facility on [DATE], with diagnosis to include a stroke with hemiplegia (paralysis) affecting the left side and dysphagia (difficulty swallowing). A quarterly Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 3, 2022 revealed that the resident was severely cognitively impaired with a BIMS score of 5 (Brief Interview for Mental Status - a tool to assess cognitive function) and required maximum assistance of staff with activities of daily living. The resident received enteral feedings to meet the resident's nutrition and hydration needs. The resident had a PEG tube (Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube [PEG tube] is passed into a 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]. A review of the resident's current physician orders and plan of care, initially order dated January 20, 2022, revealed an order for Jevity 1.5 cc (enteral feeding formula) at 60 ccs per hour continuously for 6 hours on each shift for 24 hours (totaling 1080 ccs of enteral feed and 600 cc of water in 24 hours). A review of a nutriton/dietary note dated August 8, 2022, at 12:11 PM. revealed weight that the resident's weight trend noted no significant weight change in 30/90/180 days. The resident's current weight on August 2, 2022, was 123.6 lbs. The resident was NPO (nothing by mouth) with pleasure feedings (at the request of a patient or family member, a doctor will order pleasure feeds to indulge a person's special request, even if NPO for the purpose of food as enjoyment, not proper nutrition) of puree food via teaspoon only with Speech language therapist & daughter. The entry noted that the resident was receiving enteral support, Jevity 1.5 60 cc/hr x 6 hours for total 360 cc every shift plus 100 cc water flush before & after feedings to deliver 1620 kcal/69 gms pro/1420 cc free water q day. A reassessment of the resident's estimated needs were as follows: 1404-1683 kcal (25-30 kcal/kg) 56-62 gms protein (1-1.1 gms/kg) 1404-1683 cc (1 cc/kcal). The entry indicated that the resident was able to meet 100% of estimated needs for weight maintenance & hydration with current enteral support. The plan was Will continue with current plan of care. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Observation of the resident and the resident's feeding delivery in the resident's room on October 18, 2022, at 10:15 AM revealed the label on the resident's 1500 ml Jevity 1.5 enteral feeding container was dated as opened and connected on October 17, 2022, with no time indicated. The feeding was disconnected and the tubing draped over the tube feeding pole. The tube feeding pump was noted to be in the off position and the feeding container was observed to be empty at that time. The resident was not receiving any enteral nutrition or assisted hydration at that time. Continued observation revealed Resident 10 was in bed. Her lips were very dry and chapped. There was a white film coating on her lips and around her mouth. Her teeth appeared coated with a dried brown film. A second observation October 18, 2022 at approximately 2 P.M., revealed that the resident's tube feeding was unchanged from the previous observation and the resident was still not receiving and enteral feeding delivery. An observation October 19, 2022 at approximately 10 A.M., Resident 10 was lying in bed. Her lips were very dry with chapped peeling skin. Her teeth were coated with a brown film. The resident's feeding was again disconnected and the tubing draped over the tube feeding pole, as observed on October 18, 2022 at 10:15 AM and 2 P.M. The tube feeding pump was again observed in the off position. The feeding container was empty at that time. At the time of the observation, Resident 10 was stating to the surveyor I'm hungry, I'm hungry. During an interview October 19, 2022 at approximately 2:15 P.M., the Speech Therapist confirmed that Resident 10 was receiving Speech Therapy (ST) services at the time to try to increase her by mouth food intakes. She confirmed that her nutritional needs were provided solely by the enteral tube feeding at the present time. An observation October 20, 2022 at approximately 10 A.M. of Resident 10's tube feeding, revealed a 1500 cc bottle of Jevity 1.5 was infusing at 60 cc per hour via the pump. The date and time on the bottle (indicating the date and time the bottle was hung and started infusing) was noted to be October 19, 2022 at 2:30 PM. There was 1100 ccs in the bottle and the pump was infusing at 60 cc per hour. The October 19, 2022, 2:30 PM bottle of enteral feeding should have infused 360 ccs for the 3 PM to 11 PM shift and October 20, 2022, 360 ccs for the 11PM. to 7 A.M. shift. An additional 180 ccs for the day shift (7 A. M. to 3 P.M.) at the time of the observation. The total amount to be infused was noted to be 900 ccs. However, the amount of enteral feeding in the bottle at the time of the observation October 20, 2022 at 10 A.M. was 1100 ccs, indicating that only 400 ccs had infused, not 900 ccs as when calculating the delivery rate. Based on observations during the survey it could not be determined that Resident 10 had received the physician ordered enteral feedings for October 18, 19 and 20, 2022. A review of Resident 10's weight record revealed the following: 10/20/2022 11:26 118.2 Lbs Mechanical Lift Hoyer (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	10/18/2022 11:18 127.2 Lbs Mechanical Lift Hoyer 10/7/2022 12:47 126.0 Lbs Mechanical Lift Hoyer 10/6/2022 07:20 126.0 Lbs Mechanical Lift Hoyer The weight taken on October 18, and 20, 2022 were noted to have been taken on the B unit (COVID isolation unit) by the same mechanical hoyer lift. An observation on October 20, 2022 at approximately 11:30 A.M., revealed that Employees 12 (agency nurse aide) and 17 (agency nurse aide) weighed Resident 10 via the mechanical lift scale. Resident 10 weighed 118.2 pounds. Her previous weight on October 18, 2022 was noted to be 127.2 pounds, a 9 pound weight loss or 7.08% weight loss in 2 days. During an interview conducted on October 21, 2022, at approximately 11:30 AM the director of nursing was unable to verify that the resident's enteral feeding had been administered as ordered and was unable to demonstrate that the resident received the necessary assisted nutrition and hydration to prevent weight loss and maintain adequate hydration status. 28 Pa. Code 211.12 (a)(c)(d)(1)(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** 39929 Based on review of select facility policy and clinical records and staff interviews it was determined that the facility failed develop and implement individualized pain management programs, consistent with professional standards of practice, to meet the pain management needs of two residents (Resident 37 and Resident 129), failed to administer pain medications as ordered and failed attempt non-pharmacological interventions to alleviate pain for one resident (Resident 49) out of 21 sampled residents. Findings include: A review of facility policy entitled Pain Management Policy revealed nursing staff will evaluate and document pain findings every shift. Non-drug interventions should be tried prior to medication administration and as appropriate in conjunction with medication usage to provide pain relief. Further it was noted license staff will notify the attending physician if there is unrelieved or unimproved pain. According to the US Department of Health and Human Services, Interagency Task Force, Executive Summary Report dated May 2021, for Pain Management Best Practices the development of an effective pain treatment plan after proper evaluation to establish a diagnosis with measurable outcomes that focus on improvements including quality of life (QOL), improved functionality, and Activities of Daily Living (ADLs). Achieving excellence in acute and chronic pain care depends on the following: An emphasis on an individualized patient-centered approach for diagnosis and treatment of pain is essential to establishing a therapeutic alliance between patient and clinician. Acute pain can be caused by a variety of different conditions such as trauma, burn, musculoskeletal injury, neural injury, as well as pain due to surgery/procedures in the perioperative period. A multi-modal approach that includes medications, nerve blocks, physical therapy and other modalities should be considered for acute pain conditions. A multidisciplinary approach for chronic pain across various disciplines, utilizing one or more treatment modalities, is encouraged when clinically indicated to improve outcomes. These include the following five broad treatment categories -Medications: Various classes of medications, including non-opioids and opioids, should be considered for use. The choice of medication should be based on the pain diagnosis, the mechanisms of pain, and related co-morbidities following a thorough history, physical exam, other relevant diagnostic procedures, and a risk-benefit assessment that demonstrates the benefits of a medication outweighs the risks. The goal is to limit adverse outcomes while ensuring that patients have access to medication-based treatment that can enable a better quality of life and function. Ensuring safe medication storage and appropriate disposal of excess medications is important to ensure best clinical outcomes and to protect the public health. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Restorative Therapies including those implemented by physical therapists and occupational therapists (e.g. , physiotherapy, therapeutic exercise, and other movement modalities) are valuable components of multidisciplinary, multimodal acute and chronic pain care. o Interventional Approaches including image-guided and minimally invasive procedures are available as diagnostic and therapeutic treatment modalities for acute, acute on chronic, and chronic pain when clinically indicated. A list of various types of procedures including trigger point injections, radiofrequency ablation, cryoneuroablation, neuro-modulation and other procedures are reviewed. o Behavioral Health Approaches for psychological, cognitive, emotional, behavioral, and social aspects of pain can have a significant impact on treatment outcomes. Patients with pain and behavioral health comorbidities face challenges that can exacerbate painful conditions as well as function, QOL, and ADLs. o Complementary and Integrative Health, including treatment modalities such as acupuncture, massage, movement therapies (e.g., yoga, tai chi), spirituality, among others, should be considered when clinically indicated. Effective multidisciplinary management of the potentially complex aspects of acute and chronic pain should be based A review of the clinical record revealed that Resident 37 was admitted to the facility on [DATE], with diagnoses to include neuropathy. The resident's plan of care dated April 21, 2022, identified the intervention to review pain medication efficacy and assess whether pain intensity is acceptable to resident. Physician orders dated April 21, 2022, were noted for Acetaminophen (Tylenol) Tablet 325 MG 2 tablet by mouth every 8 hours for mild pain and Acetaminophen Tablet 325 mg 2 tablets by mouth every 4 hours as needed for pain level (1-3). Resident 37's clinical record had no physician orders for pain medication for pain level above 1-3 on the pain scale. A review of Resident 37's nursing progress during October 2022 notes indicted that the resident and her daughter were concerned about her pain level. A entry dated October 2, 2022, revealed that the resident and her daughter had expressed concerns about the resident's knee pain. A entry dated October 6, 2022, revealed that the resident was crying out in pain and her daughter had called facility with concerns regarding her mother's pain. A review of a medication administration note dated October 2, 2022, at 11:38 a.m. revealed that the resident received PRN Tylenol 650 mg for pain. The resident's pain level was rated at 4 out of 10. There was no indication that the physician was consulted for the potential need to alter treatment or obtain additional orders for the treatment of the resident's pain exceeding a level 3. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The medication administration record dated October 6, 2022, revealed that the resident was yelling out in pain. There was no documented evidence that pain medication was administered and no pain level was assessed. There was no documented evidence that the physician was consulted regarding the resident's ongoing and increased pain or informed that the resident's current pain management regimen was ineffective. A review of the clinical record revealed that Resident 129 was readmitted to the facility on [DATE], with diagnoses to include diabetes, obesity and chronic obstructive pulmonary disease (a progressive lung disease). Resident 129 was readmitted to the facility October 13, 2022, following a hospitalization for treament after a fall at home resulting in a knee dislocation. She was admitted to the hospital for surgical intervention and then admitted to the facility for aftercare and therapy. Hospital discharge documentation dated October 13, 2022, revealed a left knee immobilizer as per orthopedics to be worn all the time. At the time of the survey ending October 21, 2022, there was no documented evidence of a physician's order for the resident's continued use of this brace a the facility. There was no nursing documentation from the time of the resident's admission to the date of this survey of the application or use of the brace for this resident. An admission note from the CRNP (certified registered nurse practitioner dated October 13, 2022, noted the presence of the knee immobilizer. There was no documented evidence of the resident's use of the knee brace aside from this entry. There was no documented evidence of the resident's use and staff care related to the brace. The resident's use of the brace was not included on the resident's baseline care plan or care plan. The resident had a physician order dated October 14, 2022, for oxycodone (a narcotic pain medication) 5 mg, give 1 every 8 hours as needed for pain. A review of a medication administration record (MAR) for October 2022 revealed Resident 129 was medicated with Oxycodone 5 mg on October 15, 2022 at 8:36 A.M and 4:58 P.M., October 16, 2022 at 1:20 A.M. and October 17, 2022 at 9:54 A.M. Nursing documentation dated October 17, 2022 revealed Resident 129 tested positive and was moved from the second floor to the first floor, B isolation unit (COVID unit). An x-ray dated dated October 17, 2022 at (test completed at)10:27 AM revealed a dislocated left knee prosthesis An admission MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 18, 2022, revealed that the resident was cognitively intact and required maximum assistance from staff with activities of daily living. Nursing documentation dated October 18, 2022 at 11:00 A.M. revealed a late entry note Call was made to resident's daughter, and made her aware that x-ray result reviewed by Physician with an order to send resident to the hospital as x-ray result read as dislocation to left knee. The Physician was called and informed of the x-ray result and the resident was sent to the hospital for evaluation and treatment. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a hospital history and physical dated October 18, 2022 at 12:24 PM, revealed that Resident 129 stated that she had a fall 3 days ago at the facility onto her left knee and has had left knee pain ever since. Upon admission to the hospitalER on [DATE], an xray revealed, posterior dislocation of the total knee prosthesis present with no obvious fractures. There was no documented assessment of Resident 129's left knee prior to her x-ray on October 18, 2022, and prior to her transfer to the hospital. There was no documented evidence of a pain assessment or nursing documentation related to the possible cause of the dislocated knee prosthesis. An interview the Director of Nursing (DON) on October 21, 2022, at approximately 2:00 PM revealed the facility failed to implement an effective pain management program designed to promote the resident's comfort and meet the goals for effective pain relief consistent with current standards of practice. Review of Resident 49's clinical record revealed that the resident was initially admitted to the facility on [DATE], with diagnoses to have included rheumatoid arthritis [is a chronic inflammatory disease that affects the joints that results in painful joints, swelling and stiffness in the joints] and muscle weakness. Review of the resident's care plan for the problem/need of pain initiated on September 7, 2022, indicated that the resident was at risk for pain related to arthritis with planned interventions included to administer pain medications as ordered. Physician's orders dated September 2, 2022, were noted for Acetaminophen (Tylenol) tablet 325 mg, give two tablets by mouth as needed for the pain scale level of (1-3); prior to administration attempt non-pharmacological interventions (NPI) such as 1. distraction, 2. Reposition, 3. warm/cold pack, 4. quiet space, 5. Massage, 6. low light, 7. Other. Review of Resident 49's Medication Administration Record (MAR) for September 2022, revealed that on September 5, 2022, at 8:17 PM, Tylenol was administered prior to attempting NPI and was indicated on the MAR as N/A. The facility failed to administer PRN pain medication per MD orders and failed to provide documented evidence that non-pharm interventions were attempted prior to administration. Physician's orders dated September 29, 2022, at 4:00PM, were noted for Roxicodone (an Opioid pain medication used for moderate to severe pain levels) tablet 5 gm (oxycodone HCl), give 1 tablet by mouth every 6 hours as needed for moderate pain 5-7 level. Review of the MAR for October 2022 revealed that Roxicodone was administered on October 1, 2022, at 9:29 AM, and on October 9, 2022, at 5:05 PM, and on October 17, 2022, at 3:20 AM, for a reported pain level at 8 and no documented evidence that non-pharmacological interventions were attempted prior to the administration of opioid pain medication. On October 11, 2022, at 8:56 PM, Roxicodone was administered for a reported pain level of 0 and on October 4, 2022, at 9:02 PM, the opioid was administered for a reported pain level of 4. There was no documented evidence that non-pharmacological interventions were attempted prior to administering an opioid pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing (DON) on October 21, 2022, at 2:15 PM, confirmed that the facility failed to ensure that resident's pain medications were administered as per physician's orders, and failed to ensure that non-pharmacological interventions were attempted prior to the administration of pain medications. 28 Pa. Code 211.12 (a)(c)(d)(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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review, observation and staff interview, it was determined that the facility failed to provide person-centered care to a resident receiving dialysis services for one of two residents sampled (Resident 41). Findings include: Clinical record revealed that Resident 41 was admitted to the facility on [DATE] with diagnoses to include chronic kidney disease, on dialysis (a method by which the blood is cleaned outside the body). The resident had a left upper arm AV fistula (procedure that connects an artery to a vein in preparation for dialysis) for dialysis treatments. A quarterly Minimum Data Set assessment dated [DATE], revealed that Resident 41 was severely cognitively impaired, required maximum assistance of staff for activities of daily living and was receiving dialysis treatments. The resident had a current physician order, initially dated January 18, 2022, to Monitor AVF on (L) upper Arm for signs and symptoms of Infection, Bleeding and positive function. The resident had a current physician order and care plan dated October 2022 for dialysis treatments three times a week on Mondays, Wednesdays and Fridays. A review of the resident's medication administration and treatment records dated October 2022 do not indicate that a bruit and thrill (a vascular murmur, is a sound and indicator of how well the dialysis access site is functioning) was checked in order to ensure functioning of the AVF site. Observation and record review revealed that Resident 41 was transferred to the B, Covid isolation unit after testing positive for COVID 19 on October 13, 2022. Observation on October 19, 2022, revealed multiple dialysis to the facility communication forms folded up in the bottom of a bag on the back of the resident's wheelchair. The observed communication forms from the dialysis center post treatment, There was no evidence at the time of the survey ending October 21, 2022, that these communication records, between the dialysis treatment center and the facility, had been reviewed by licensed and professional staff. During an interview October 19, 2022, Employee 21 (agency LPN) stated he was not aware of a dialysis communication log/record/binder for Resident 41. Employee 21 stated that he was unaware of any communication records/forms located in the pocket on the back of the resident's wheelchair. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview October 19, 2022 at 3 P.M. the DON confirmed that the communication forms are to be reviewed by the licensed nurse and placed in the individual resident dialysis binder located at the nurses station. She confirmed that a dialysis communication binder could not be located at the B unit nurses station. She further confirmed that staff was not monitoring the residents AVF and a physician order was obtained, following surveyor inquiry, on October 21, 2022 at 7 AM, to check the resident's AVF bruit and thrill every shift. 28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing Services

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on observations, a review of clinical records and staff interview, it was determined that the facility failed to ensure each resident is provided with necessary behavioral health care in a timely manner to attain or maintain the highest practicable mental and psychosocial well-being for one of five residents reviewed (Resident 24). Findings include: Review of Resident 24's clinical record revealed admission to the facility on [DATE], and had diagnoses of Major Depression (major loss of interest in pleasurable activities, characterized by change is sleep patterns, appetite and/or daily routine); and Unspecified Dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability). An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's needs) of Resident 24, dated August 3, 2022, revealed that the resident's BIMS score (brief interview for mental status) indicated she was moderately impaired with a score of 12 out of 15. A review of Resident 24's clinical record revealed the resident had a physician's order dated March 1, 2022, for 15-minute safety checks. Observations of Resident 24 were made on October 18, 2022, at approximately 12:20 p.m. through 12:45 p. m. The resident was observed removing multiple towels, sheets and other linen from a linen cart in the hallway. The resident threw a pile of sheets and towels behind her and formed a pile of towels on the handrail in front of her in the hallway. During this observation period, no staff intervened or checked on the resident's activities/whereabouts during this time. At approximately 12:45, a staff member came down the hallway and picked up the linens and put all of the linens in bags to be sent to laundry. Observations of Resident 24 were made on October 19, 2022, at approximately 9:20 a.m., through 9:50 a.m. The resident was observed in bed. A cup of what appeared to be chocolate milk had been spilled/thrown to the end of her bed as well as on her breakfast tray. Chocolate milk was observed to be spilled on her blankets and the floor. During this observation period, no staff checked on resident. Observations of Resident 24 were made on October 21, 2022, at approximately 1:20 p.m., Resident 24 was observed to remove briefs from a linen cart and throw them onto the floor. Review of Resident 24's behavioral care plan initiated July 26, 2022, addressed a behavioral problem of smearing feces on food trays and walls. However, the observed behaviors of pulling items from linen carts was not noted on the resident's care plan. Interventions in place for the resident's behavioral problems included monitoring the resident's behavior to attempt to determine underlying cause and providing paper trays for meals. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 24's behavioral monitoring from October 1-20, 2022, revealed that the monitoring records that the facility was not capturing resident behaviors. On all days reviewed including days with observations of behaviors displayed on October 18, 19, and 21, 2022, the monitoring record reflected that the resident had no behaviors. There was no documented evidence that the facility had developed and implemented a person-centered care plan that included and supported the behavioral health care needs of Resident 24. There was no documented evidence that the facility had provided the resident with meaningful activities which promoted engagement and that addressed the resident's customary routines, interests, preferences, etc. and enhance the resident's well-being; Interview with the Nursing Home Administrator on October 21 2022, at approximately 2:00 PM revealed that the facility was unable to provide evidence that the facility had provided the necessary care and services to address the resident's behavioral health needs. 28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing Services 28 Pa. Code 211.16(a) Social Services 28 Pa. Code 211.11(d)(e) Resident care plan

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39929 Based on observations, a review of clinical records and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered plan to address a resident's dementia-related behavioral symptoms for one out of 21 residents reviewed (Residents 24) Findings include: A review of the clinical record revealed that Resident 24 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia without behavioral disturbances (a decline affecting memory, normal thinking, communicating which make it difficult to perform normal activities of daily living such as dressing, eating and bathing). An annual Minimum Data Set assessment (a federally mandated standardized assessment completed periodically to plan resident care) dated August 3, 2022, indicated that the resident was moderately cognitively impaired with a BIMS (brief interview for mental status - a tool to assess cognitive status) of 12, indicating moderate cognitive impairment. Review of Resident 24's clinical record revealed the resident was on 15-minute safety checks. Observations of Resident 24 throughout the days of the survey from October 18-21, 2022, revealed that the resident was displaying behavioral symptoms such as emptying linen carts and throwing linens throughout hallway, throwing and spilling drinks from her food tray. During the observation periods as the resident displayed these behaviors staff were not conducting the 15 minute checks on resident, as surveyor observed these behaviors without staff intervention/monitoring present for periods longer than 15 minutes. Review of the resident's behavior tracking for the month of October 2022 revealed that the resident's behavior was not consistently monitored in October 2022, through the time of the survey ending October 21, 2022. There were multiple occasions during the month of October 2022, on which no entries were made indicating that the resident's behavior was monitored on the date. Further review of the behavior tracking revealed that the behavior tracking did not include tracking of the interventions attempted to reduce any noted behavioral symptoms, such as the resident's smearing feces, and their effectiveness. The resident's current care plan, in effect at the time of the survey of October 21, 2022, did not identify the specific dementia related behaviors the resident exhibits and individualized person-centered interventions to address each of these behaviors. The facility failed to develop and implement an individualized person-centered plan to address, modify and manage the residents' 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. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Nursing on October 21, 2022, at approximately 9:30 a.m., confirmed that the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to address dementia-related behaviors and consistent and accurate monitoring of the resident's dementia related behaviors and any approaches used to manage or modify those behaviors. Refer F740 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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41460 Based on a review of clinical records and staff interview it was determined that the attending physician failed to timely act on a pharmacist's identified irregularity in the drug regimen of one of five residents sampled (Resident 12) Findings include: A review of the clinical record revealed that Resident 12 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder. Physician's orders dated July 15, 2021, revealed an order for Cymbalta [an antidepressant used to treat depression and anxiety] 20 mg orally once daily for major depressive disorder. A review of the Drug Regimen Reviews conducted by the facility's consultant pharmacist January 18, 2022, revealed a recommendation to attempt a GDR (gradual dose reduction) for Resident's 12's Cymbalta dose. The physician did not respond to the recommendation until March 29, 2022 (greater than 2-months later). Additionally, the physician's response was noted as psych consult. No documented evidence that a GDR was attempted and that they physician provided sufficient documented evidence that the resident continued to require the same dosage of the medication. Interview with the Director of Nursing (DON) on September 22, 2022, at 11:30 AM, confirmed that there was no evidence that the physician timely addressed a GDR recommendation and provided a sufficient clinical rationale for decline a GDR. 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.2(a) Physician services 28 Pa. Code 211.5 (g)(h) Clinical records

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on clinical record review and staff interviews, it was determined that the facility failed to attempt a gradual dose reduction of a psychoactive drug for one resident (Resident 12) out of 20 sampled residents. Findings include: A review of the clinical record revealed that Resident 12 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder. A physician order dated July 15, 2021, was noted for Cymbalta [an antidepressant used to treat depression and anxiety] 20 mg orally once daily for major depressive disorder. A review of the Drug Regimen Reviews conducted by the facility's consultant pharmacist January 18, 2022, revealed a recommendation to the physician to attempt a GDR for Resident's 12's Cymbalta dose. Resident 12's Medication Administration Record (MAR) for October 2022, revealed that the resident continued to receive Cymbalta 20 mg one time a day for major depressive disorder. Interview with the Director of Nursing (DON), on October 21, 2022, at approximately 2:30 PM, confirmed that there was no documented evidence that a GDR had been attempted or physician documented resident specific clinical rationale for the resident's continued use of the current dosage of Cymbalta. Refer F756 28 Pa. Code 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services. 28 Pa. Code 211.5 (f)(g)(h) Clinical records. 28 Pa. Code 211.2(a) Physician services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 26142 Based on review of resident clinical records and staff interview it was revealed that the facility failed to assure that two of 14 residents reviewed were free of significant medication errors (Residents 73 and A1). Findings include: A review of the clinical record revealed that Resident 73 had physician's orders dated October 12, 2022, for Lantus Solution (Insulin Glargine, a long acting insulin), Inject 22 unit subcutaneously one time a day for Diabetes. A medication administration record (MAR) for October 2022 indicated that the Insulin was to be administered at 9 A.M. The MAR indicated that on October 19, 2022, the 9 A.M. insulin was given to Resident 73 at 12:07 P.M. A review of the clinical record revealed that Resident A1 had physician's orders dated October 13, 2022 for Metformin (an oral diabetic medication)Tablet 500 MG Give 1 tablet by mouth two times a day, with meals. A medication administration record (MAR) for October 2022 indicated that the metformin was to be given at 9 A.M. and 5 P.M. The MAR indicated that on October 19, 2022, the 9 A.M. metformin were given to Resident A1 at 11:47 A.M. Resident 30 had current physician's orders initially dated January 18, 2021, for GLUCOSCAN TEST (a method to monitor the blood sugar) in the morning every Monday, Wednesday, Fridays for diabetes and to notify MD of below 60 or above 300. The resident's medication administration record (MAR) for October 2022 indicated that the glucoscan was to be completed at 7:30 A.M The MAR indicated that on October 19, 2022, the 7:30 A.M. glucoscan was completed for Resident 30 at 11:45 A.M. When interviewed on April 27, 2022, the Director of Nursing Services confirmed that the antidiabetic medications were not administered timely which would be one hour prior or one hour after the noted administration times. 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing Services. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy 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, observation and staff interview, it was determined that the facility failed to assist one resident in obtaining necessary dental services for one of 20 sampled residents (Resident 10). Findings include: Clinical record review revealed that Resident 10, a cognitively impaired resident, was admitted to the facility on [DATE], with diagnoses to include a stroke with left sided hemiplegia (paralysis). During initial tour of the facility on October 18, 2022, at approximately 10 AM Resident 10 was observed with dry, cracked lips and upper and lower teeth encrusted with a brown film. The resident was unable to comment about the condition of her teeth at the time of the observation. During an interview December 19, 2022, at approximately 2 PM the Director of Nursing confirmed that the facility had not identified the poor condition of Resident 10's teeth and no dental services had been offered to the resident and/or the resident's representative. 28 Pa. Code 211.12 (a)(c)(1)(d)(3)(5) Nursing services 28. Pa. Code 211.15(a) Dental Services

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 43944 Based on review of the facility's 4-week menu cycle and resident and staff interviews, it was determined that the facility failed to serve a varied menu demonstrating reasonable efforts to meet individual resident needs and food preferences and failed to ensure that these menus were updated periodically and reviewed by the facility's dietitian. Findings included: During interviews with Residents 3, 7, 14, 34, and 51 conducted during the survey ending October 21, 2022, revealed that the residents complained that the facility's current menu lacked variety, similar foods were served consecutively, and that too many sandwiches were offered for lunch. During an interview with Resident 3 on October 19, 2022, at 1:30 PM, the resident stated that the facility's menus are not seasonally updated or updated timely. The resident stated that the Spring/Summer menu did not go into effect until Mid-June 2022 and that as of October 19, 2022, the Fall/Winter Menu had not yet been initiated and served. Resident 3 also stated that the menus lacked variety and food items offered were repetitious. The resident said that many of the items that were offered on the main and alternate menu were items that were listed on the Menu Substitutions list available. Residents 7, 14, 34 and 51 voiced concerns during the survey with the frequency that sandwiches are served. A review of the lunch meal menus for the current menu cycle revealed that at the lunch meals, the main entree and alternates planned during the 4-week menu cycle were sandwiches. The other alternative available from the Meal Substitution menu were also sandwiches. Interview with the facility's Certified Dietary Manager on October 20, 2022, at 11:40 AM, revealed that the facility offers a meal substitution list that the resident could request if they received a meal that was disliked. Review of the facility's Meal Substitutions included choices of a peanut butter and jelly sandwich, grilled cheese sandwich, ham sandwich, hot dog, and a fried egg sandwich. Review of the facility's 4-week menu cycle Spring/Summer Menu: Week 1, revealed that for lunch Mondays through Sunday, sandwiches were served eleven times out of fourteen lunch meals. The meal patterns for both the main entree and alternative the planned lunch meal were sandwiches. Further review of Week 1 revealed that on Tuesdays the planned alternative for lunch would be a hamburger and then Shepard's pie (beef entree) was the planned main entree at dinner with the alternative of veal (beef). Dinner on Wednesday, Salisbury steak was offered as the alternative (beef). Dinner on Thursday was roast beef as the main entree. Saturday dinner offered beef stew as the main entree at dinner and then for lunch on Saturday, chili was the main entree (beef), and a cheeseburger was the alternative meal at dinner. Beef was the main and alternative item served consecutive days. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's 4-week menu cycle Spring/Summer Menu: Week 2, revealed that for lunch Mondays through Sunday, sandwiches were served ten times out of fourteen lunch meals. At some lunches during week 2 the meal patterns for both the main entree and alternative were sandwiches. Review of the facility's Spring/Summer: Week 2 menu, revealed that on Mondays the planned dinner main entree was tomato beef casserole with an alternate entree of beef stew. The planned dinner for Tuesday was Shepard's pie, in which contains beef, and then the planned lunch for Wednesday was an opened face meatloaf sandwich. Additionally, the planned main entree for dinner on Thursday was Salisbury steak, and then the Friday main entree for lunch was stuffed cabbage, and then the main entree for lunch on Saturday was a cheeseburger. The Week 2 menu lacked variety and the meal pattern with meal entrees and alternatives contained beef consecutively throughout the week. Review of the facility's 4-week menu cycle Spring/Summer Menu: Week 3, revealed that for lunch Mondays through Sunday, sandwiches were served twelve times out of fourteen lunch meals. Most of the planned lunches during week 3 were sandwiches for both the main entree and alternative with the offered Meal Substitution list choices sandwiches. Review of Week 3 revealed that poultry was served at consecutive meals. The alternative lunch on Monday was chicken salad, then at dinner the alternative was a turkey burger. Tuesday the alternative dinner was chicken rice casserole, and then the main entree for lunch on Wednesday was a chicken patty on a bun, and the alternate for dinner on Wednesday was a turkey burger. The main entree for lunch on Thursday was a turkey burger and the dinner main entree was Parmesan breaded chicken. The Week 3 menu lacked variety and the meal patterns for lunch mostly consisted of sandwiches for the main and alternative entrees and would further be substituted with a sandwich for residents that disliked the main and alternative. Additionally, several of the meals offered poultry for consecutively entrees throughout the week. Review of the facility's 4-week menu cycle Spring/Summer Menu: Week 4, revealed that for lunch Mondays through Sunday, sandwiches were served thirteen times out of fourteen lunch meals. Most of the planned lunches during week 4 were sandwiches for both the main entree and alternative with the offered Meal Substitution list choices sandwiches. Review of the planned Week 4 revealed that beef was served at consecutive meals. The alternative lunch entree for lunch on Monday was a hamburger and then for dinner the main entree was meatloaf. The main entree for lunch on Wednesday was beef BBQ on a bun, and the alternative for dinner was beef stew. The alternative dinner on Saturday was meat loaf, and then the main entree for lunch on Saturday was a cheeseburger. The Week 4 menu lacked variety and the meal patterns for lunch mostly consisted of sandwiches for the main and alternative entrees. Sandwiches were also planned for residents who disliked both the main entree and alternate Several of the meals offered beef consecutively as the entrees throughout the week. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the facility's registered dietitian on October 18, 2022, at 11:30 AM, revealed that the menus were planned prior to her employment at the facility and that the current menu did contain repetitions foods/meals and lacked variety. The RD stated that she planned to review the facility's Fall/Winter menu when the CDM completed all 4-weeks. Interview with the CDM on October 21, 2022, at 10:00 AM, confirmed that the facility's menu lacked variety and that the food items served were repetitive. 28 Pa. Code 211.6(c) Dietary services. 28 Pa. Code 201.29(a)(i)(j) Resident rights.

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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, a 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). Review of a facility policy entitled Frozen Supplement Storage indicated that food is stored a minimum of 12-inches above the floor and 18 inches from the ceiling or other clean surfaces, and is protected from splash, overhead pipes, or other contamination. Refrigeration temperatures should be between 35-49 degrees Fahrenheit. Further review of a facility policy entitled Safe Food Preparation and Handling identified that milk, eggs, and egg products were potentially hazardous foods and should be refrigerated below 41 degrees Fahrenheit. The initial tour of the kitchen was conducted with the Employee 11, a cook, on October 18, 2022, at 9:11 AM, revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness, were identified during observations: White spilled substance on the bottom of the Ice cream/milk cooler along with ice crystal build-up in the corner. Cold beverages such as pre-poured milk in cups, shakes, and magic cups (a frozen supplement) were observed on an open cart and uncovered. The cook supervisor reported that these items were set-up for the lunch tray-line service. The thermometer in the cooler read 55 degrees. The frozen magic cups felt soft to touch and some of the lids had evidence of the product coming through the lids due to melting. Observation in the walk-in cooler that there were shelled eggs. The cook supervisor stated that those were the eggs used for fried eggs that were offered on the facility's always available menu and provided as requested by some of the residents. The shelled eggs were not stamped as pasteurized [is a process that involves heating a substance to a temperature that is too high for bacteria and viruses to survive]. Employee 11 could not provide evidence that the eggs were pasteurized. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observed that inside the walk-in freezer that on the top shelf there were several loosely wrapped salmon filets that were not dated. In the dumpster area cartons of milk were observed on the ground and one of the dumpster lids was left opened. Inside of the walk-in milk cooler 3 milk crates were observed in direct contact with the floor. Observation in the kitchen area on October 20, 2022, at 11:25 AM, revealed that there was a N-95 mask on a counter near kitchen equipment. Employee 11 stated that it was his mask. Further observation on October 20, 2022, at 11:45 AM, revealed an employee serving the prepared grilled cheese sandwich used his gloved hands to plate the sandwiches and had while wearing the gloves stepped away from the tray-line to restock food. With same gloved hands, the employee touched other kitchen surfaces and returned to serving the tray-line and did not change gloves and perform hand hygiene. Interview with the Food Service Director (FSD) on October 21, 2022, at 10:35 AM, confirmed that the confirmed that the dietary department was to be maintained in a sanitary manner and food served using sanitary practices. 28 Pa. Code 207.2(a) Administrator's responsibility 28 Pa Code 211.6(c) Dietary services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 26142 Based on a review of clinical records and employee job descriptions, it was determined that the facility's administration failed to effectively use its resources to ensure adherence to infection control standards to prevent the spread of COVID-19 virus in the building. Findings included: Immediate Jeopardy was called on October 20, 2022, at 10:30 AM due to the facility's failure to ensure that staff working on the COVID isolation unit located on the B-first floor unit consistently followed isolation protocols to prevent the spread of the COVID 19 virus. There was no evidence at the time of the survey that the staff working on the COVID isolation unit consistently followed isolation procedures. It was verified that agency nursing staff working in the facility were not provided with the necessary training regarding the facility's infection control policy and procedures to mitigate the spread of COVID 19. Additional breaks in infection control practices were observed related to the staff conducting van transport, meal delivery and housekeeping services. These staff members also did not adhere to infection control practices, by failing to perform cleaning procedures of applicable equipment after exposure to COVID-19. A review of the job description for the Nursing Home Administrator (no signature or date) revealed that the NHA administers, directs and coordinates overall operation of the facility. To assure optimum health, care and safety of residents and the protection of their personal property rights. Ensures that the facility complies with all established standards and regulations on the Federal, State and Local levels. Administers, executes and enforces all established facility policies and procedures. The NHA establishes, together with departments, policies pertaining to patient care, personnel, medical staff, financial status and maintenance of properties, according to directives of the governing board. Insure compliance with such policies. Updates and revises policies as need arises. A review o the Job Description for Direction of Nursing Services signed April 20, 2020, revealed the purpose of the director of nursing is to plan, organizes, develops and directs the day-to-day functions of the Nursing Services Department in accordance with current Federal, State and Local standards, guidelines and regulations that govern the facility, and as may be directed by the administrator, to ensure that the highest degree of quality of care is maintained at all times. The job duties to include, Develops and participates in the planning, conducting and scheduling of timely in-service training classes that provides instructional on how to do your job, and ensures a well educated Nursing Services Department. Develops , implements and maintains an effective orientation program that orients the new employee to the facility, its policies and procedures, and to his/her position. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The deficiency cited under the Code of Federal Regulatory Groups for Long Term Care, Infection Prevention and Control (F880) 483.12(a)(1) Infection Control, revealed that the NHA and DON failed to fulfill the essential job duties for ensuring the safety of the residents and adherence to regulatory guidelines. Refer F880 28 Pa. Code: 201.12 (a) Responsibility of licensee 28 Pa. Code: 201.18(b)(1) Management 28 Pa. Code: 201.18(b)(3) Management 28 Pa. Code:211.12(c)(d)(5) Nursing Services

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 41460 Based on review of the facility's written agreement between the facility and the Hospice Care Agency and staff interview, it was determined the facility failed to ensure coordination of necessary care and services for one of one sampled resident (Resident 70) receiving Hospice services. Findings include: Review of the hospice contract between the facility and the Hospice agency providing Hospice care and services to Resident 70, revealed that there was no evidence that the facility designated a staff person to participate in the ongoing communication between the facility and the Hospice agency. Interview with the Director of Nursing on October 21, 2022, at approximately 11:00 a.m., confirmed that the facility did not note and identify, in their agreements with the Hospice agency, the member of the facility's interdisciplinary team responsible for working with the hospice representative to coordinate care to the residents. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services. 28 Pa. Code 201.21(c) Use of outside resources. 28 Pa. Code 201.18(e)(2)(3) Management.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety 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 observations, a review of clinical records, select facility policy, current CDC (Centers for Disease Control and Prevention) and PAHAN (Pennsylvania Health Alert Network) infection control guidance and staff interview, it was determined that the facility failed to consistently implement infection control precautions necessary to deter the spread of the COVID-19 virus in the facility, which placed residents in immediate jeopardy due to the increased risk of likely spread of COVID-19 that may potentially cause serious illness, hospitalization and/or death. Findings include: A review of the Pennsylvania Department of Health 2022 - PAHAN - 663 - 10-04-UPD dated October 4, 2022, subject: UPDATE: Interim Infection Prevention and Control Recommendations for Healthcare Settings during the COVID-19 Pandemic. This HAN Update provides comprehensive information regarding infection prevention and control for COVID-19 in healthcare settings based on changes made by CDC on September 23, 2022. Key definitions referenced in the PAHAN included a close contact: someone who is within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period, during their infectious period. The infectious period begins from 2 days before illness onset or for asymptomatic (without symptoms) patients, 2 days prior to specimen collection date of the positive test. Source control definition: Use of well- fitting cloth masks, well-fitting facemasks, or respirators to cover a person's mouth and nose to prevent the spread of respiratory secretions when breathing, talking, sneezing, or coughing. Up to date: In general, being up to date on COVID-19 vaccination includes receiving all vaccines according to the recommendations provided by CDC. This includes a primary series of vaccine, booster doses, and any recommended third doses for immunocompromised people. For specifics, refer to CDC guidance. Isolation for residents: The term isolations refer to the implementation of measures for a resident with COVID-19 infection during their infectious period, to prevent transmission to other residents, health care professionals, or visitors. Isolation in long term care facility residents includes the use of standard and transmission- based precautions for COVID-19 and a private room with a private bathroom or another resident with laboratory confirmed COVID-19, preferably in a COVID Care Unit and restrict the resident to their room with the door closed. (In some circumstances keeping the door closed may pose resident safety risks and the door might need to remain open. If the door remains open, work with facility engineers to implement strategies to minimize airflow into the hallway). An outbreak is considered one or more COVID-19 cases in a facility. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	If residents develop signs and symptoms of COVID-19 perform viral testing, implement isolation while tests are pending and place unvaccinated roommate(s) under quarantine immediately. Do not place a person with suspected COVID-19 into a COVID care unit prior to confirmation of infection by positive test result. Managing residents with exposure: to include use of standard and transmission- based precautions for COVID-19 and always maintain source control while around others; and be placed in a single room. If limited single rooms are available or if numerous residents are simultaneously identified to have known to have SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should shelter- in-place at their current location while being monitored for evidence of SARS-CoV-2; and restrict the resident to their room; and Quarantine for residents should extend 10 days from the date of the last exposure, regardless of the results of testing, unless the resident should become symptomatic or positive for SARS-CoV-2 during that period. Limited circumstances where units or facilities might be considered zones. For COVID-care units (RED zone), for admission units designated for unvaccinated residents (YELLOW zone)- a unit based or facility-wide approach to outbreak response where all residents are undergoing quarantine (YELLOW zone) because none are fully vaccinated, or the facility has been advised to do so to respond to an outbreak with ongoing transmission. The facility has a licensed and certified bed capacity of 174 beds. On October 18, 2022, the facility census was 82. At the time the survey began on October 18, 2022, there were 16 residents positive for COVID-19. Observations during a tour of the facility on October 18, 2022, revealed that two of these residents resided on the A units in private rooms. The additional 14 residents resided on the B wing. There were two hallways in the B wing, 4 residents on one hallway and 10 on the second hallway. The unit had a separate entrance and exits, which were clearly marked as such. A review of the facility's policy entitled, COVID-19 protocols and procedures; outbreak protocol revised October 2021, revealed that As per the facility infectious disease policy and procedure, traditional standards for care may need to be altered to maximize health care flexibility to adjust to the COVID-19 pandemic. The facility will continue to use CMS, CDC and DOH for surveillance guidelines and recommendations. Confirmed SARS-CoV 2 (COVID-19) positive residents who triggers positive on a Rapid Antigen viral test will be transferred to the B wing, (Red) isolation zone. Droplet precautions will be initiated when either a suspected or confirmed infectious or communicable disease is identified. Please follow CDC recommendations for COVID-19 (droplet precautions). Droplet precautions to included the following: PPE: -Staff, providers and visitors must wear gown, gloves, mask and eye goggles at all times while in the room; goggles and masks as needed for splashes; Remove PPE before leaving the room; do not wear PPE outside the room unless absolutely necessary. The facility's COVID-19 Infection Control policy had not been reviewed and revised since October 2021 to reflect the most current guidance recommended by the CDC. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation of the B unit COVID, isolation unit, October 18, 2022, at approximately 10 A.M., revealed Employee 12 (agency nurse aide) and Employee 13 (housekeeping) in the 1 hallway with their N-95 masks below their noses. These two employees were not correctly wearing PPE. An additional observation on October 18, 2022, at approximately 11:45 AM revealed Employee 12 was again observed on the 1 hallway, with her N-95 mask below her nose. The observation was confirmed by the facility Infection control nurse at the time of the observation. She verbally educated Employee 12 to adjust her mask to cover her nose. At 1:30 P.M. Employee 12 was again observed on the B, COVID isolation unit for the third time with her N-95 mask under her nose despite prior reeducation by the facility's infection control nurse earlier that shift. At that time Employee 20 (agency nurse aide) was also observed wearing her N95 mask under her nose. An observation October 19, 2022 at 10 A.M., 12 PM and again at 2 PM, Employee 21 (agency LPN) was observed on the COVID isolation unit (B unit) wearing his N95 mask under his nose with the bottom strap hanging under his chin. An observation October 19, 2022, at approximately 11 AM revealed Employee 15 (agency nurse aide) exited the B unit (COVID isolation unit) into the outside hallway (neutral areas of nursing offices, activities and business office) with her coat on over her isolation gown. She also had taken off her N95 face mask upon entering the neutral area. Employee 15 did not doff her contaminated isolation gown prior to entering the neutral area. During an interview at the time of the observation, Employee 15 stated that she was on her way outside of the facility for her break. Employee 15 stated that this was the first shift she had worked at the facility. Employee 15 said she had not received any education or inservicing on facility policy's and procedures including infection control and COVID procedures. She stated that she did not know that she was to doff the isolation gown before leaving the B unit. An observation October 20, 2022 at 11:20 A.M., revealed Employee 14 (agency nurse aide) walked into the Covid isolation B unit without PPE. Once in the COVID unit, she donned PPE. The resident room doors were open to the hallway. Employee 14 then left the B unit through the entrance doors to the green area, picked up resident supplies and returned to the Covid isolation unit, without doffing contaminated PPE and donning new PPE. A review of the facility policy for food transport cart cleaning for COVID-19 isolation, reviewed October 2020 revealed The facility strives to give all residents meals at an acceptable temperature, even those residents who reside in the COVID19 yellow isolation (quarantine). EPA approved ECO-lab smart power (cleaning solution) will be used to disinfect food transport carts prior to exiting COVID-19 isolation units. The cleaning procedure was as follows: 1. Food transport cart will be disinfected with ECO labs Smart Power solution. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a. Smart Power will be stored in the janitors closets located in the isolation zone. b. After completed meals, trays are collected and placed in the food transport cart. The nurse aide or designated staff member will obtain Smart Power ans spray each tray in the cart. c. The cart will then be closed and the nurse aide or designee will spray the outside of the cart focusing on high touch areas such as handles. d. The cart will sit in the yellow zone for at least 60 seconds after it is sprayed. 2. The food transport cart will be removed from the isolation zone and placed outside of the isolation zone. a. The dietary staff will re-spray the outside of the food transport cart and the cart will sit for at least 60 seconds. b. The food cart will then be transported via the biohazard service elevator (red elevator) and taken to the dietary department. This policy was last updated in October 2020 and did not reflect the facility's current COVID-19 outbreak, including use of the current B unit covid isolation unit (Red zone), not yellow zone as noted in the policy. Observation on October 18, 2022, at approximately 10 AM on the B unit outside the closed doors to the COVID isolation unit revealed two partially eaten resident meals from the prior night's dinner remaining were on a food cart. The eating utensils and dinnerware were on top of the trays. Additional observation at 3 PM that afternoon revealed that the same two residents trays had not been removed from the cart. An observation October 18, 2022 at approximately 12 P.M., revealed that dietary staff pushed the meal delivery cart through the closed doors of the B unit, hallway 1, (COVID-19 positive) isolation unit. The two nurse aides assigned to the unit, distributed the 10 resident trays to the residents on that hall. The nurse aides then, without cleaning the food cart or changing their PPE, left the red hallway through the doors marked entrance and brought the food delivery cart through the area marked green (indicating a COVID free zone) wearing their contaminated PPE. The aides then entered hallway 2 and passed the remaining lunch meal trays. At approximately 12:45 P.M., the nurse aides picked up the resident trays, placed the trays back onto the meal delivery cart on hallway 2. The aides brought the meal cart through the green zone and reentered the 1 hallway on the red unit, placed the resident trays onto the meal cart and took meal cart through the door marked entrance to the COVID unit. The meal delivery cart was not disinfected by nursing staff or dietary staff before entering the green unit. The two nurse aides did not change PPE prior to leaving the COVID 1 hallway, entering a non-covid green zone and then entering the 2 hallway of the COVID unit. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation October 19, 2022 at approximately 12 PM. revealed that the both the dietary and nursing staff used the same practice for meal delivery. Dietary staff brought the meal cart to the B wing isolation doors. The nurse aides then brought the truck into the 1 hallway and proceeded to pass the resident lunch trays. Again, the nurse aides transported the meal cart from the 1 hallway to the 2 hallway by going thru the green zone. The nurse aides did not doff their PPE prior to leaving the 1 hallway and don clean PPE prior to entering the 2 hallway. The meal cart was not cleaned and disinfected prior to leaving the red zone for dietary pick up and transport back to the kitchen. An observation of the housekeeping closet on the B unit on October 18, 2022 at approximately 12:25 P.M., revealed that the closet was located outside COVID unit red isolation hallways. There were no bottles of the Smart Power cleaning solution on the covid B unit hallways. An interview October 18, 2022 at approximately 1 PM Employee 12 (agency na) stated that all the chemicals were located in the housekeeping closet, outside the isolation zone. She stated that staff on the COVID-19 unit would have to come out of the isolation zone, into the neutral/green zone to retrieve the spray bottles of cleaner. An observation October 18, 2022 at approximately 10:15 A.M., Employee 13 (housekeeping) took into the B isolation, hallway 1 on the covid unit. Observation revealed that she cleaned several resident rooms then brought the housekeeping cart back through the closed door of the isolation, covid unit, through the neutral/green zone and placed back into the housekeeping closet without disinfecting the cart. During an interview October 18, 2022, at approximately 2 PM the Director of Housekeeping stated that each housekeeper has their own designated cart. She attempts to keep her staff assignments consistent but at times she has to assign staff to different areas, including the COVID, isolation unit. She stated that the housekeeping carts are returned to the basement via the elevator at the end of staff shifts. She stated that the cart assigned to the COVID isolation unit is to be cleaned at the end of the shift, prior to returning to the basement. An interview on October 18, 2022 at approximately 11 AM, Employee 13 (housekeeping) stated that on the B unit, the Smart Power cleaner is kept in the housekeeping closet on the clean side outside of the Red isolation hallways. She stated that nursing takes the bottles of disinfectant out of the closet when needed for use on the tray trucks. An observation of the B unit, October 18, 2022 at approximately 11 AM revealed that the two medication carts designated for the 1 and 2 hallways (COVID areas) were both stored in the green area outside the COVID quarantine resident hallways. An observation October 18, 2022 a t 11:45 A.M. Employee 22 (LPN) pushed the 1 hallway medication cart onto the quarantine unit. At approximately 12:30 PM, Employee 2 (LPN)moved the medication cart through the closed doors from the red quarantine unit into a green zone. This nurse did not clean the medication cart before entering the green area (COVID free area). (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation of the B unit, October 19, 2022, at approximately 9:30 AM, Employee 21 (agency LPN) was administering residents medications on the 1 hallway (COVID). She finished administering medications and moved the medication cart out of the isolation hallway to the green area. She then took the second medication cart from the green area, through the closed doors back into the COVID unit, hallway 2. After finishing the medication pass, she then returned the medication cart to the green area outside the isolation unit. The nurse did not clean the cart prior to placing it in the green area. A review of facility transportation schedule dated October 20, 2022, and an interview with Employee 20 (van driver) revealed that Resident 41, a COVID positive resident, was transported in the facility van to a dialysis at 12 PM. After this resident was dropped off at dialysis, the van driver picked up two other residents who had been dropped off earlier at physicians' offices. An additional resident was then picked up at the facility and dropped off at a physicians office. Resident 41 was then picked up from dialysis and returned to the facility. Employee 20 (van driver) stated that the van transport schedule for the day was so full that he did not have the time to clean the van after the transport of the COVID positive resident to and from her appointment and prior to other residents utilizing the van. Due to the facility's COVID outbreak status during the survey ending October 21, 2022, all employees (unless COVID positive within the past 30 days) were to be tested twice weekly for COVID-19. The testing was to occur prior to working a shift at the facility. On October 19, 2022, Employee 23 (agency LPN) reported for work at 7 AM. Observation revealed that Employee 23 was COVID tested in the lobby of the facility. However, Employee 23 immediately walked through the first floor, green unit to enter the B unit (COVID positive isolation unit) entrance potentially exposing residents and staff on the first floor A unit to COVID 19 infection. Approximately 15 minutes later, Employee 23's COVID test was noted to be positive and nursing staff advised her to leave work at the facility. During an interview October 19, 2022, at approximately 11 A.M., the DON confirmed the possible exposure in the facility as the result of the testing practice of not requiring employees to wait for their results prior to reporting to the residents units. Interview with the Infection Preventionist on October 20, 2022, at 1:00 PM confirmed that the facility presently utilized the services of a large amount of agency nursing staff. She stated that it was difficult to ensure all staff, including agency staff, consistently follow infection control practices, including properly wearing PPE, such as masks. The IP was unable to provide documented evidence that agency staff were educated on the facility's infection control policies and procedures to mitigate the spread of COVID-19 and were trained on the specific tasks and duties for working on the COVID-19 unit to maintain necessary precautions. Immediate Jeopardy was called on October 20, 2022, at 10:30 AM due to the facility's failure to ensure that staff working on the COVID isolation unit located on the B-first floor unit consistently followed isolation protocols to prevent the spread of the COVID 19 virus. There was no evidence at the time of the survey that the staff working on the COVID isolation unit consistently followed isolation procedures. It was verified that agency nursing staff working in the facility were not provided with the necessary training regarding the facility's infection control policy and procedures to mitigate the spread of COVID 19. Additional breaks in infection control practices were observed related to the staff conducting van transport, meal delivery and housekeeping services. These staff members also did not adhere to infection control practices, by failing to perform cleaning procedures of applicable equipment after exposure to COVID-19. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The IJ template was provided to the facility on [DATE], to the facility at 12 PM. An immediate plan of correction was requested and received on October 20, 2022 at 4:18 P.M. The plan included: All staff will be re-educated on the COVID Isolation Procedures. Education will be given to each employee coming on shift beginning with 3-11 shift October 20, 2022 and each shift thereafter Agency Staff will do on-boarding education on their first shift at PVM, which will include the COVID Isolation Procedures. Starting with 3-11 shift October 20, 2022. All staff will be COVID swabbed prior to starting on their assigned unit beginning with 11-7 on October 20, 2022. Staff will not report to their unit/department prior to obtaining results. This procedure will be ongoing. Transport van will be disinfected prior to the next transport at 9AM on October 21,2022 Signage will be increased on the COVID unit to alert staff where to find PPE and disinfectant and how to DON/DOFF PPE by October 20, 2022. Medication Carts will be cleaned per procedure and remain on red unit by October 20, 2022 Dietary carts and/or trays will be cleaned per procedure prior to leaving the unit by October 20,2022 The Immediate Jeopardy was lifted on October 21, 2022, at 5 PM when implementation of the plan of correction was verified. 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing services 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.10(a)(c)(d) Resident care policies

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Report COVID19 data to residents and families. 26142 Based on review of information provided by the facility, resident and staff interview, it was determined that the facility failed to ensure that residents, resident representatives and families were timely informed of cumulative, confirmed and suspected COVID-19 infections in the facility. Findings include: Review of facility line listing revealed a staff member tested positive for COVID-19 on September 26, 2022, and facility wide testing was initiated. Interview with the Nursing Home Administrator (NHA), on October 18, 2022, at 9:30 AM revealed that the facility notifies residents representatives and families of confirmed residents and/or staff COVID-19 within the facility via a mass email and post on social media platform Facebook. Information provided by the facility indicated that on October 11, 2022, the NHA instructed another staff member to send out the attached via mass email and instructed a different staff member to please post on our Facebook page. Review of the attachment dated October 11, 2022, announced to resident family members and visitors that the facility had several residents at {the facility} triggered a positive result on a COVID test during the past two days. Additionally, the memo, which was to be posted on social media and sent out via email indicated that those residents who tested positive for COVID were moved to red isolation on the B wing and yellow isolation if they were exposed to a positive resident. There was no evidence that the facility Facebook page was timely updated or that each family member/ resident representative was emailed with each new resident and/or staff member positive COVID-19 case. Further review of the facility line listing revealed staff and/or residents tested positive for COVID-19 on October 5, 2022, October 7, 2022, October 10, 2022, October 12, 2022, October 13, 2022, October 14, 2022, and October 17, 2022. Interviews conducted with cognitively intact residents who wish to remain anonymous, on October 19, 2022, at 9:45 AM, revealed that they only know about COVID activity in the facility because they ask the staff. According to those residents interviewed, there is no formal notification to the residents regarding residents and/or staff testing positive for COVID-19. Interview with the Nursing Home Administrator on October 20, 2022, at approximately 2:00 PM confirmed that the facility could not provide documented evidence that the facility timely informed and updated residents, representatives and families of confirmed or suspected COVID-19 activity in the facility. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(e)(1)(2)(3) Management

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Perform COVID19 testing on residents and staff. 26142 Based on staff interview and a review of the facility's COVID-19 testing records, standards established by the Centers for Medicare & Medicaid Services, select facility policies and documentation, and staff interviews it was determined the facility failed to timely and consistently conduct testing of all staff, provide evidence that all residents were tested , and develop a policy to include procedures to address residents who refuse testing for COVID-19 surveillance. Findings include: A review of Center for Clinical Standards and Quality/Survey & Certification Group, Ref: QSO - 20-38-NH dated August 26, 2020, revised September 23, 2022, revealed a final ruling, which establishes Long-Term Care (LTC) Facility Testing Requirements for Staff and Residents. Specifically, facilities are required to test residents and staff, including individuals providing services under arrangement and volunteers, for COVID-19 based on parameters set forth by the Secretary of Health and Human Services. According to this directive, an outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately (but not earlier than 24 hours after the exposure) and refers to the CDC (Center for Disease Control) Interim Infection prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. According to the CDC, the approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all resident and HCP identified as close contacts or on the affected unit(s) if using broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test (Day 1, day 3, and Day 5 after exposure). If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. A review of facility COVID tracking sheets dated October 2022, revealed a line listing of all the current staff, agency staff, and contracted staff working in the facility. The tracking sheets did not identify which staff had tested positive for COVID-19 during the month of October 2022. Further, there was no indication of the COVID positive status for the past 90 days for the additional staff listed on this form to indicate if they should be tested in the noted prior 90-day period (if tested positive 90 days prior, should not be retested for Covid 19). Review of facility staffing sheet dated October 19, 2022, revealed that Employee 9, agency licensed practical nurse, worked 9 AM to 3 PM. There was no documented evidence that Employee 9 had been tested for COVID-19 during the month of October 2022. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility memo dated September 15, 2021, provided by the facility on October 18, 2022, indicated that the facility policy requires all employees and agency personnel, whether vaccinate or unvaccinated, to get tested for COVID-19 at least twice each week for persons working 32 or more hours per week and at least once each week for persons working less than 32 hours per week. Staff that work every other weekend must be tested each Saturday and Sunday on every weekend that is worked. According to the facility COVID tracking sheets dated October 2022, there are three staff members who work every other weekend in the facility. There was no evidence that two of the three staff members were tested both Saturday and Sunday as instructed in the facility policy memo. (Employee 10 and Employee 11). The facility failed to provide evidence during the survey ending October 21, 2022, that all residents were tested accordingly during the facility's COVID-19 outbreak. Additionally, there was no evidence provided that the facility's current COVID-19 testing policy and procedures included procedures to address residents who refuse testing for COVID-19. The facility failed to follow guidance set forth by CMS and the CDC to ensure the facility continues to respond effectively to the COVID-19 Public Health Emergency. 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 211.12(a)(d) Resident care policies

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observation and staff interview it was determined that the facility failed to ensure that essential heating equipment was in safe operating condition in one resident room (room [ROOM NUMBER]). Findings include: During a tour of the facility on October 18, 2022, at 10:30 A.M., observation in resident room [ROOM NUMBER], revealed that the heating unit was removed from the wall and placed on the floor and was not operational. During an interview October 29, 2022 at 2 P.M., the Nursing Home Administrator confirmed that the heating unit was not presently not functional. 28 Pa Code 207.2(a) Administrators responsibility

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observation and resident and staff interview, it was determined that the facility failed to demonstrate a functioning maintenance program to ensure that a resident's bed is maintained in working order for one of 20 residents sampled (Resident 27). Findings include: An observation on October 18, 2022 at 10:45 A.M., revealed that the bed in resident room [ROOM NUMBER]-C was not functioning properly as the bed control did not work. During an interview at the time of the survey, Resident 27 stated that her bed control didn't work. Resident 27 stated that she told nursing staff that her bed was not working but that it has yet to be repaired. During an interview October 18, 2022 at 2 :20 P.M., the Nursing Home Administrator stated that he was unaware of Resident 27's broken bed and that all residents beds should be in working order. 28 Pa Code 207.2(a) Administrators responsibility

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observation and staff interview it was determined that the facility failed to maintain a functioning call bell in a resident's room (resident room [ROOM NUMBER]). Findings include: An observation October 18, 2022, at 10:35 A.M. revealed an inoperable call bell in resident room [ROOM NUMBER] B. During an interview October 19, 2022, at 1:30 P.M., the Nursing Home Administrator confirmed the call bell in that resident room was not functional. 28 Pa Code 205.67(j)(k) Electric requirements for existing and new construction