STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395564	A. Building B. Wing	02/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Rehabilitation & Healthcare Center	500 West Hospital Street Taylor, PA 18517

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on observations, review of clinical records and incident reports, and staff interview, it was determined that the facility failed to honor a resident's request to choose schedules/daily routines for showers for one resident out of 19 sampled (Resident 20). Findings include: A review of the clinical record revealed that Resident 20 was admitted to the facility on [DATE], with diagnoses, which included dementia with behavioral disturbance (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). Review of Resident 20's clinical record also revealed that the resident had a history of refusing showers and displaying behaviors of being combative with care. Review of a information submitted by the facility revealed that Resident 20 brought a concern to the attention of the facility's administration alleging that staff sprayed the resident with water during a shower the resident had received on the evening of January 18, 2022. According to the facility incident report, the facility determined that there was no evidence of abuse of the resident. It was noted that the facility had changed Resident 20's shower schedule to the evening shift and the incident that occurred on January 18, 2022, was the first evening shower the resident had received since the change. Resident 20 stated that the resident did not want to shower that evening, but staff had showered the resident despite the resident's preference. During an interview with the Nursing Home Administrator on February 3, 2022, at approximately 1:00 p.m. it was confirmed that the facility had not honored the resident's request to decline a shower that evening. 28 Pa. Code 201.29(j) Resident rights 28 Pa. Code 211.12(c) Nursing services

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26228 Based on review of clinical records and transfer notices and staff interview it was determined the facility failed to provide written notices of facility initiated transfers to the hospital to the resident, the residents' representative and representatives of the state Ombudsman, when a resident is transferred to the hospital for four of four residents reviewed (Residents 69, 81, 79, and 83). Findings include: A review of the clinical record revealed that Resident 69 was transferred to the hospital on [DATE] and was readmitted to the facility on [DATE]. The resident was again transferred from the facility and admitted to the hospital on [DATE] and was readmitted to the facility on [DATE]. A review of the clinical record revealed that Resident 81 was transferred to the hospital on [DATE] and was readmitted to the facility on [DATE]. The resident was again transferred from the facility and admitted to the hospital on [DATE] and was readmitted to the facility on [DATE]. A review of the clinical record revealed that Resident 79 was transferred to the hospital on [DATE] and was readmitted to the facility on [DATE]. A review of the clinical record revealed that Resident 83 was transferred to the hospital on [DATE] and expired at the hospital on [DATE]. The facility failed to provide documented evidence that the residents and their residents' representatives received written notice of these transfers. The facility was unable to provide evidence that a representative of the office of the state Ombudsman was notified of the transfers. Interview with the Administrator on February 3, 2022, at approximately 10:30 a.m. confirmed there was no documentation that the residents and their representatives were provided written transfer notices. The administrator also confirmed that there was no documented evidence that the written notices of facility initiated transfers were provided to a representative of the office of the state Ombudsman 28 Pa. Code 201.29(h) Resident rights 28 Pa. Code 201.14(a) Responsibility of Licensee

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26228 Based on a review of clinical records and staff interview it was determined that the facility failed to provide evidence of written information of the facility's bed hold policy provided upon transfer to the hospital of four residents out of four residents reviewed (Residents 69, 81, 79, and 83). Findings include: A review of the clinical record revealed that Resident 69 was transferred to the hospital on [DATE] and was readmitted to the facility on [DATE]. The resident was again transferred from the facility and admitted to the hospital on [DATE] and was readmitted to the facility on [DATE]. A review of the clinical record revealed that Resident 81 was transferred to the hospital on [DATE], and was readmitted to the facility on [DATE]. The resident was again transferred from the facility and admitted to the hospital on [DATE] and was readmitted to the facility on [DATE]. A review of the clinical record revealed that Resident 79 was transferred to the hospital on [DATE] and was readmitted to the facility on [DATE]. A review of the clinical record revealed that Resident 83 was transferred to the hospital on [DATE]. The resident expired at the hospital on [DATE]. The facility was unable to provide documented evidence that the facility had provided the residents and/or the residents' representatives written information, at the time of transfer, of the specifics of the facility's bed hold policies, including notice of the duration of the bed-hold policy. Interview with the Administrator on February 3, 2022, at approximately 10:30 a.m. confirmed there was no documentation that the resident or residents' representative received the specifics of the facility's bed hold policies. 28 Pa Code 201.18 (e)(1) Management 28 Pa Code 201.29 (b)(d)(f) Resident rights

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26228 Based on a review of clinical records and the Resident Assessment Instrument and staff interviews, it was determined that the facility failed to ensure the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of four residents out of 19 records sampled (Residents 40, 69, 81, and 79). Findings include: A review of Resident 40's quarterly MDS Assessments dated December 13, 2021, indicated in Section J0200 that a pain assessment interview should be conducted. Section J0300 to J0600 (Pain Assessment Interview questions) all indicated not assessed. Section J0700 asks should the staff assessment for pain be conducted and the answer was no. There was no indication that Resident 40's pain was assessed on the December 13, 2021 quarterly MDS. A review of Resident 69's significant change MDS assessment dated [DATE], revealed in Section K0300 Weight Loss that there was no loss of 5% or more in the last month or loss of 10% or more in last 6 months. Review of Resident 69's clinical record indicated revealed that the resident's weight on November 5, 2021, was 164.8 pounds. The resident's weight on January 11, 2022, indicated that Resident 69 weighed 147.0 pounds, a 17.8 pound and 10.8% weight loss. A review of Resident 81's quarterly MDS assessment dated [DATE], revealed in Section N0410 Medications Received that Resident 81 received an antipsychotic medication during the entire 7 days of the look back period, which was confirmed by review of the resident's Medication Administration Record for December 2021. However, in section N0450 Antipsychotic Medication Review it was noted that antipsychotic medications were received. A review of Resident 79's significant MDS assessment dated [DATE], revealed in Section M0100 Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage indicated that Resident 79 had one unstageable pressure injury, presenting as a deep tissue injury, that was present on admission. Review of the clinical record revealed that Resident 79 was readmitted from the hospital on January 14, 2022. A readmission nursing assessment dated [DATE] noted the resident had no skin impairment. A nurses note dated January 21, 2022 at 11:00 AM noted a deep tissue injury was identified on the resident's right heel, seven days after readmission from the hospital. Interview with the Director of Nursing on February 3, 2022 at 9:30 a.m. confirmed the MDS errors for Residents 40, 69, 81, and 79. 28 Pa. Code 211.5(g)(h) Clinical records 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on clinical record review and staff interview, it was determined that the facility failed review and revise a resident's comprehensive care plan to meet the current needs of one resident out of 19 sampled residents (Resident 28). Findings included A review of the clinical record revealed that Resident 28 was admitted to the facility on [DATE], with diagnoses that included dementia with behavioral disturbance. Further review of Resident 28's clinical record revealed a physician's order for hospice services on December 2, 2021. The resident was discharged from hospice care on January 24, 2022. A review of the resident's current plan of care revealed a plan to provide hospice services initially dated August 5, 2020. The resident's plan of care was not revised and updated upon discharge from hospice care on January 24, 2022, as of review on February 3, 2022. Interview with the Director of Nursing (DON) on February 3, 2021, at approximately 1:30 PM confirmed the facility's failure to revise the resident's care plan in response to changes in the resident's status. 28 Pa. Code 211.11 (d)(e) Resident care plan

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456 Based on a review of clinical records and staff interview it was determined that the facility failed to follow physician orders for daily weights for one out of 19 sampled residents (Resident 79). Findings include: A review of the clinical record revealed that Resident 79 was readmitted to the facility on [DATE], with diagnoses including Alzheimer's disease and hypertension. A physician order dated January 21, 2022, was noted to obtain daily weights in the AM (morning) to monitor fluid status/edema. Review of the resident's January 2022 and February 2022 records revealed no documented evidence that staff had obtained daily weights as ordered by the physician. It was noted that the resident refused or other, to see nurses notes. However, there was no documented evidence in nurses notes to indicate why the resident's weights were not obtained or the reason for the resident's refusals. Interview with the assistant Director of Nursing (DON) on February 3, 2022 at 2:00 PM confirmed that there was no documented evidence that daily weights were completed as ordered by the physician. 28 Pa. Code 211.12 (a)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.5(f)(g)(h) Clinical records.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records and select facility incident reports, observations and staff interview it was determined that the facility failed to timely and consistently provide person-centered care and planned services to prevent the development of a pressure sore for one resident (Resident 79) out of three sampled residents with skin integrity concerns. Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address areas of risk. ACP (The American College of Physicians is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e. , support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of the clinical record revealed that Resident 79 was readmitted to the facility on [DATE], with diagnoses to include Alzheimer's Disease and right shoulder fracture. A review of a Significant Change Minimum Data Set assessment dated [DATE], (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) revealed that the resident was severely cognitively impaired with a BIMS (Brief Interview Mental Screener) score of 7 (a score of 0-7 indicates severe cognitive impairment), required extensive assistance with the assistance of two people with bed mobility (how the resident moves about in bed) and transferring (how the resident moves between the bed and the chair), was at risk for developing pressure sores, and had one unstageable pressure injury presenting as a deep tissue injury (DTI-persistent non-blanchable deep red, purple, or maroon areas of intact skin, non-intact skin, or blood filled blisters). A review of the resident's Braden scale for predicting pressure sores dated January 21, 2022, revealed that the resident was at high risk for developing a pressure sore. Review of the resident's care plan initially dated January 15, 2019 noted the resident was at risk for alteration in skin integrity related to incontinent episodes, weakness, and immobility. Planned interventions to maintain skin integrity included to encourage and assist to reposition and to encourage/assist to suspend/float heels as able when in bed. Heelbows (protective padded sleeve which protects the heel) while in bed. Further review of the clinical revealed no documented evidence that the care planned interventions were implemented to maintain the resident's skin integrity to the extent possible. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurses note dated January 21, 2022 at 11:06 AM noted a DTI (deep tissue injury) to the resident's right heel. A facility incident report dated January 21, 2022 noted the DTI was dark purple and measured 3 cm x 3 cm x 10cm. The incident report noted the resident was recently out to the hospital for a fractured right humerus (shoulder). The resident was noted to have increased edema to the right lower extremity. The resident was noted to have previously been independent in his room but now required assistance. Immediate actions taken was to place the resident on a turn and reposition program and heel bows when in bed. A physician order dated January 21, 2022 was noted for skin prep (skin protectant) to both heels twice daily for prevention. A physician order dated January 23, 2022 was noted for skin prep to right heel twice daily every day and evening shift for wound care. A wound consultant note dated February 1, 2022, indicated that the resident had a purple maroon localized area of discolored intact skin with blood filled blister at the root of the right heel which measured 2 cm x 3 cm x 0 cm. The area was described as an unstageable pressure ulcer/injury of the right heel due to DTI. The plan included to cleanse affected area with normal saline solution or wound cleanser and apply skin prep every shift and as needed; off load pressure to the affected area; continue heel protectors to bilateral extremities or heels up device. A physician order dated February 2, 2022, was noted to cleanse right heel with normal saline solution or wound cleanser and apply skin prep to right heel every shift for wound care. Observation on February 3, 2022 at 1:30 PM revealed that Resident 79 was seated in a wheelchair and was wearing non-skid socks. The resident's right heel was observed directly in contact with the floor. An interview with the director of nursing (DON) on February 3, 2022, at approximately 2:00 PM confirmed that the facility was unable to demonstrate the consistent implementation of measures planned to prevent the development of Resident 79's deep tissue injury. The DON failed to provide documented evidence interventions to alleviate pressure on the resident's right heel when out of bed in his wheelchair were attempted to relieve pressure and promote healing of the deep tissue injury on the resident's right heel. 28 Pa. Code 211.12(a)(c)(d)(1)(3)(5) Nursing services. 28 Pa. Code 211.5(f) Clinical records.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review of clinical records and staff interview it was determined that the facility failed to develop a comprehensive plan to address the behavioral health needs of one of 19 sampled residents (Resident 10). Findings include: Review of the clinical record revealed that Resident 10 was admitted to the facility on [DATE], and had diagnoses, which included schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania). Review of Resident 10's clinical record revealed she was deemed a PASRR (Pennsylvania preadmission screening resident review) level II, with specialized mental health services to be provided by the facility. A quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated November 4, 2021, indicated that Resident 10 had a BIMS (brief screener that aids in detecting cognitive impairment) score of 12 indicating moderate cognitive impairment. Review of a Psychological reevaluation dated September 22, 2021, indicated that Resident 10 continued to have depressive and increased anxiety symptoms. Recommendations included individual psychotherapy (one to five times monthly) to reduce emotional symptoms due to continued depressive symptoms. A Psychiatric Evaluation dated October 5, 2021, indicated that Resident 10 had a continued need for behavioral health services. Further review of the resident's clinical record conducted during survey ending February 5, 2022, revealed no evidence of further psychological services provided to the resident after October 5, 2021. During an interview with the Nursing Home Administrator (NHA), on February 3, 2022, at approximately 9:00 a.m., the NHA confirmed that Resident 10 had not received psychological services since October 5, 2021, due to the termination of the contract with the psychological services provider and the facility's current psychiatrist was not providing these services to residents. 28 Pa. Code 201.21 Use of outside resources 28 Pa. Code 201.18 (e)(6) Management

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 13456 Based on review of clinical records and staff interview, it was determined that the facility to conduct gradual dose reductions or provide medical justification for the continued dosage of psychotropic medications for two residents (Resident 10 and ---) of 5 residents sampled. Findings include: Review of the clinical record revealed that Resident 10 was admitted to the facility on [DATE], and had diagnoses, which included schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania). Review of Resident 10' s current physician orders revealed an order for Lithium Carbonate Capsule 150 mg 1 capsule by mouth at bedtime and Lithium Carbonate Capsule 300 mg 1 capsule by mouth one time a day. A review of a Consultation Report from the Pharmacist dated December 02, 2021, revealed a recommendation to the physician to consider a gradual dose reduction for Lithium Carbonate Capsule 150 mg 1 capsule by mouth at bedtime and Lithium Carbonate Capsule 300 mg 1 capsule by mouth one time a day. The physician's response indicated to continue current medication, but failed to provide the clinical rationale for the continued use and declination of the GDR. The facility failed to ensure that a gradual dose reduction was attempted in two separate quarters with at least one month in between the attempts in the first year. Interview with the Nursing Home Administrator on February 3, 2022 at approx. 11:00 AM confirmed that a gradual dose reduction of Resident 10's dose of Lithium had not been attempted timely. Resident 32 was readmitted to the facility on [DATE] with diagnosis which include other specified depressive episodes and was ordered on the antidepressant medication on October 23, 2019 Zoloft 25 mg one tablet by mouth daily. Monthly pharmacy reviews dated June 4, 2021, December 3, 2021 and January 28, 2022 indicated the resident has a history of depression and continues with depressed mood. The clinical record did not indicate the resident had any increased depressive episodes. There was no evidence a GDR was attempted since the resident was prescribed the medication on October of 2019. Interview with the NHA on February 3, 2022 could not provide any documented evidence tat a GDR was attempted on this resident. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28. Pa. Code 211.2(a) Physician services 28 Pa. Code 211.5(g)(h) Clinical records

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26228 Based on review of clinical records and staff interview, it was determined that the facility failed to offer routine annual dental services for three Medicaid payor sources out of 19 residents sampled. (Resident 40, 42, 69, and 81). Findings include: Review of Resident 40's clinical record indicated that the resident was admitted to the facility on [DATE], and that the resident's payor source was Medicaid. Review of Resident 42's clinical record indicated that the resident was admitted to the facility on [DATE], and that the resident's payor source was Medicaid. Review of Resident 69's clinical record indicated that the resident was admitted to the facility on [DATE], and that the resident's payor source was Medicaid. Review of Resident 81's clinical record indicated that the resident was admitted to the facility on [DATE], and that the resident's payor source was Medicaid. There was no documented evidence that these residents had been offered dental services in the past year. Interview with the Director of Nursing on February 3, 2021 at 1:00 p.m. confirmed that the facility had no documented evidence that Resident's 40, 42, 69, and 81 were offered routine dental services in the past year. 28 Pa. Code 211.12(c)(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. 21738 Based on observation, review of the facility's planned cycle menu, and staff interview it was determined that the facility failed to pre-plan menus to meet nutritional adequacy for texture modified diets to include mechanical soft (modified in consistency to reduce the amount of chewing required to consume food) , mince/moist (includes foods that are soft, moist, and can be easily formed into a ball, contains small lumps that can be broken up with the tongue rather than the teeth), and puree (foods have soft, pudding-like consistency) diets. Findings include: Observation of the trayline in the food and nutrition services department on February 2, 2022 at approximately 6:30 PM revealed that dietary staff had concluded preparing the dinner meal trays for residents. Review of the written planned menu for the meal revealed the following: for a mechanical soft diet serve 4 ounce soft vegetable (no specific vegetable noted); for a minced and moist diet serve 4 ounce ground vegetable (no specific vegetable noted); and for a puree diet serve 4 ounce puree vegetable (no specific vegetable noted). Interview with employee 6 (cook/supervisor) confirmed that the menu did not designate what vegetable to serve for the aforementioned diets and it was up to her to decide which vegetable to serve if the vegetable is not specifically designated for each diet on the menu. Interview with the food and nutrition services director on February 3, 2022, at approximately 1:00 PM confirmed that the written menu did not consistently designate a specific vegetable for mechanical soft, mince and moist, and puree diets to ensure variety and nutritional adequacy of menus for all diets. 28 Pa. Code 211.6 (a)(b)(d)(e) Dietary services

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	395564	A. Building B. Wing	02/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Rehabilitation & Healthcare Center	500 West Hospital Street Taylor, PA 18517

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 21738 Based on observation, review of clinical records, menu extensions, and staff and resident interviews, it was determined that the facility failed to ensure that a resident identified with swallowing difficulties was consistently served food in a form to meet this resident's individual needs for one resident out of 19 sampled (Resident 73). Findings include: Review of the clinical record revealed that Resident 73 had diagnoses, which included oral pharyngeal dysphagia (swallowing problems that occur in the mouth and/or throat). A diet order dated January 14, 2022, was noted for a regular mechanical soft ground texture diet (modified in consistency to reduce the amount of chewing to consume foods). Observation during the lunch meal on February 2, 2022, at approximately 12:00 PM revealed that Resident 79 was not eating the pulled pork sandwich, which was on her meal tray. The pulled pork was observed to have approximate one-inch pieces of pork on the sandwich. Interview with Resident 79 at this time revealed that the resident stated that the pork was not ground enough for ease of swallowing. Review of the facility's menu extension for the lunch meal for a mechanical soft diet ground texture diet on this date indicated a ground pulled pork sandwich was to be served. Interview with the food and nutrition services director on February 2, 2022 at approximately 1:00 PM confirmed that the facility failed to provide the pulled pork sandwich in a form to meet the resident's needs for safe swallowing. 28 Pa. Code 211.12 (a)(c)(d)(3)(5) Nursing services.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 13456 Based on a review of select facility policy and Quality Assurance and Quality Assurance and Process Improvement (QAPI) (the facility's Quality Assessment and Assurance committee) attendance sheets and staff interview, it was determined that the facility failed to ensure the required committee members met at least quarterly or as per facility policy. Findings include: A review of the meeting minutes for QAPI (Quality Assurance and Performance Improvement) from January 2021 through January 2022 revealed the following members were to attend meetings and serve on the committee: administrator; director of nursing; medical director; dietary representative; pharmacy representative; social service representative; activities representative; environmental service representative; infection control representative; rehabilitative representative; staff development representative; medical records representative and any others assigned by the administrator. A review of the meeting minutes revealed that the facility held monthly QA meetings. The medical director failed to attend or participate virtually any meetings held from June 2021 through October 2021, failing to demonstrate at least quarterly participation. 28 Pa. Code 201.18(e)(2)(3) Management.

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F 0888 Level of Harm - Actual harm Residents Affected - Few	Ensure staff are vaccinated for COVID-19 13456 Based on a review of select facility policy, standards established by the Centers for Medicare and Medicaid Services and the facility's employee vaccination data and staff interviews, it was determined that the facility failed to fully develop and implement policies and procedures to ensure that all staff were vaccinated for COVID-19. Review of facility employee vaccination status information revealed, that as of February 5, 2022, the facility's staff vaccination rate was 98.3 % and there were four COVID resident infections since January 27, 2022 (Residents 29, 57, 73, and Resident 12) Findings include: According to the CMS Memorandum QSO-22-07 On November 5, 2021, CMS published an IFC with comment period (86 FR 61555), entitled Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination, revising the infection control requirements that most Medicare- and Medicaid-certified providers and suppliers must meet to participate in the Medicare and Medicaid programs. These changes are necessary to protect the health and safety of patients and staff during the COVID-19 public health emergency. At the time of the survey ending February 5, 2022, the facility did not meet the requirement of staff vaccinated; and one or more components of the policies and procedures had not been developed and implemented. Review of the facility policy entitled CMS Vaccine Mandate-COVID-19, dated November 11, 2021, revealed that effective December 5, 2021, all individuals must receive their first vaccine (either the single dose vaccine or the first dose of the two-step vaccine) against Covid-19 as a condition of employment and complete the vaccine course by January 4, 2022, unless there is a valid reason for exemption or accommodations. Review of facility employee vaccination status information revealed, that as of February 5, 2022, the facility's vaccination rate of employees fully vaccinated was 98.3 %. The facility failed to provide evidence that Employee 7 (contracted phlebotomist) and Employee 8 (contracted transportation aide/ambulance) were vaccinated or had a qualifying exemption. The facility's vaccine policy failed to include procedures for defining and implementing the necessary mitigation and additional precautionary measures that would be taken for those employees that were unvaccinated with a qualifying exemption to ensure the implementation of the additional precautions used to accommodate these staff members and intended to mitigate the transmission and spread of Covid-19, for all staff who are not fully vaccinated for Covid-19 and failed to include a contingency plan for unvaccinated employees without a qualifying exemption, including deadlines and timeframes for resolution. (continued on next page)

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F 0888 Level of Harm - Actual harm Residents Affected - Few	At the time of the survey, ending February 5, 2022, and based on a review the previous 9 days since the effective date of January 27, 2022, there was a current COVID-19 outbreak of among residents which included a total of 4 residents positive for Covid-19 on these dates (Residents 29, February 2, 2022, Resident 57, February 2, 2022, Resident 73, February 2, 2022, Resident 12, and February 10, 2022) Interview with the Nursing Home Administrator (NHA) on February 5, 2022, at 1:00 PM, confirmed that not all staff were vaccinated against the COVID-19 virus required by the CMS mandate and that there were omissions in the facility's policy and procedures. 28 Pa. Code 201.14 (a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1)(d)(e)(1) Management

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 13456 Based on review of personnel records and interview with staff, it was determined the facility failed to provide training on the facility specific abuse policy and procedures upon hire for five of five newly hired employees reviewed (Employees 1, 2, 3, 4 and 5). Findings include: Review of Employee 1's personnel record revealed a hire date of November 17, 2021. Further review of Employee 1's personnel record failed to reveal documented evidence that the employee was provided training on the facility specific abuse training upon hire. Review of Employee 2's personnel record revealed a hire date of November 10, 2021. Further review of Employee 2's personnel record failed to reveal evidence of abuse training upon hire. Review of Employee 3's personnel record did not reveal a hire date. Interview with the director of Human Resources on February 5, 2022 at 10:00 AM revealed that Employee 3 was a contracted employee, but was unable to provide a date of hire or evidence that the employee received training on the facility's abuse policy and procedure. Review of Employee 4's personnel record revealed a hire date of February 2, 2022. Further review of Employee 4's personnel record failed to reveal evidence of abuse training upon hire. Review of Employee 5's personnel record revealed a hire date of February 1, 2022. Further review of Employee 5's personnel record failed to reveal evidence of abuse training upon hire. Interview with the Nursing Home Adminstrator and the Human Resource (HR) Director on February 5, 2022, at 11:30 AM revealed that the HR Director stated he reviews the company handbook with new employees and confirmed that he does not review the facility's specific policy, entitled Abuse Policy with these new employees. The facility was unable to provide documented evidence that these employees were trained on the facility's specific abuse policy and procedures upon hire. 28 Pa. Code 201.19 Personnel policies and procedures 28 Pa. Code 201.20(b) Staff development