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	395564	A. Building B. Wing	12/02/2022

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 41520 Based on review of select facility polity, the minutes from Resident Food Council Meeting and resident and staff interviews, it was determined that the facility to accurately record grievances brought forth at resident group meetings and the facility's response to these expressed grievances. Findings include: A review of facility policy entitled, Grievances/Complaints, Filing with a policy review date of March 24, 2022, revealed that the residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the State Ombudsman). The policy indicates, All grievances , complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response. A review of the minutes from the Food Council Meeting minutes held September 29, 2022, revealed that 15 residents attended the meeting. During that the resident voiced concerns about sausage, bacon and oatmeal served. The facility's response was that these items will be looked at to determine how they are prepared, and make sure they are cooked and presented better. Additionally, residents were asking for cola and ginger ale. A review of the minutes from the Food Council Meeting minutes held November 27, 2022, revealed that 14 residents attended the meeting. During that meeting, resident voiced concerns over food could be hotter, residents requesting soda, food items on tray do not correlate with the meal ticket on the tray. These meeting minutes lacked documented evidence that the facility had revisited these concerns during the next meeting to ensure that the areas had been satisfactorily addressed or remained problematic for the residents. The meeting minutes did not include specific agenda items discussed or addressed old business and new business to demonstrate the facility's efforts to resolve the residents' concerns and to evaluate resident satisfaction and assess improvement Review of the facility's grievance logs from February 2022 to present revealed no documented evidence of the residents' food concerns or complaints expressed in the residents' food committee meetings in order to assess improvement, monitor problem resolution efforts by the facility and evaluate resident satisfaction. (continued on next page)

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

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with five cognitively intact residents (Residents 85, 68, 52, 7, and 9) conducted during the survey ending December 2, 2022, revealed that the residents stated that the complaints and concerns they bring up during food council meeting minutes never seem to be addressed by the facility. The residents stated that the food committee meetings occur immediately after the resident council meetings, which are monthly. The residents interviewed during the survey ending December 2, 2022, continued to voice complaints about not receiving soda, the food items served on their meals trays do not match their preferences as noted on their tray card, hot foods continue to be served cold and that overall the food served is terrible. Interview with the Nursing Home Administrator on December 2, 2022, confirmed that the residents had continued complaints regarding food temperatures, soda availability, and meal tickets failing to correlate with items received on the meal tray at the time of the survey ending December 2, 2022, and that the facility failed to demonstrate sufficient efforts to resolve the complaints voiced at the Food Committee Meetings. 28 Pa. Code 201.18 (e)(1)(4) Management 28 Pa. Code 201.29 (i)(j) Resident Rights

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 26228 Based on a review of clinical records, and staff interview, it was determined that the facility failed to timely consult with the physician and notify resident's representative, of a significant weight loss, for three residents out of 8 sampled residents (Resident 5, 57 and 69). Findings include: A review of the clinical record revealed that Resident 5 was admitted to the facility on [DATE], with diagnoses to include depression, anxiety, and dementia. An admission Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated July 18, 2022, indicated that the resident has both short, and long term memory problems and is moderately cognitively impaired. Resident 5's clinical record reflected a primary representative (responsible party and emergency contact #1) as a family member (Son). A continued review of the resident's clinical record, weight record revealed the following recorded weights: July 13, 2022 178.4 pounds July 27, 2022 162.6 pounds 15.8 lbs 8.85% significant weight loss August 22, 2022 161.8 pounds September 14, 2022 150.6 pounds 11.2 lbs 6.9% significant weight loss There was no documented evidence that the facility had notified the physician or resident representative of the significant, unplanned weight loss noted on July 27, 2022 and September 14, 2022. A review of the clinical record revealed that Resident 57 was admitted to the facility on [DATE], with diagnoses to include depression, and dementia. A significant change MDS dated [DATE], indicated that the resident has both short, and long term memory problems and is severly cognitively impaired. Resident 57's clinical record reflected a dual primary representative (responsible party and emergency contact #1) as a family member (Son) and a friend. A continued review of the resident's clinical record, weight record revealed the following recorded weights: March 8, 2022 141.2 pounds (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	August 1, 2022 123.6 pounds 17.6 lb 12.46% significant weight loss There was no documented evidence that the facility had notified the physician or resident representative of the significant, unplanned weight loss noted on August 1, 2022. A review of the clinical record revealed that Resident 69 was admitted to the facility on [DATE], with diagnoses to include hypertension, depression, and dementia. A quarterly MDS dated [DATE], indicated that the resident has both short, and long term memory problems and is severly cognitively impaired. Resident 57's clinical record reflected a primary representative (responsible party and emergency contact #1) as a family member (Daughter). A continued review of the resident's clinical record, weight record revealed the following recorded weights: September 2, 2022 147.2 pounds October 3, 2022 136.0 pounds 11.2 lbs 7.6% significant weight loss There was no documented evidence that the facility had notified the physician or resident representative of the significant, unplanned weight loss noted on October 3, 2022. Interview with the Administrator on December 2, 2022 at 11:30 a.m. confirmed that there was no documentation that the physician and and resident's representative were notified of the significant weight losses for Resident 5, 57 and 69. 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 0622 Level of Harm - Potential for minimal harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26228 Based on clinical record review and staff interview, it was determined that the facility failed to ensure necessary resident information was communicated to the receiving health care provider for five of 19 sampled residents (Residents 36, 54, 76, 77 and 249). Findings include: A review of the clinical record of Resident 54 revealed that the resident was transferred and admitted to the hospital on November 7, 2022, and returned to the facility November 9, 2022. A review of Resident 76's clinical record revealed a hospitalization on [DATE], and returned to the facility on [DATE] . A review of Resident 77's clinical record revealed the resident was transferred from the facility and admitted to the hospital on May 4, 2022. The resident was readmitted to the facility on [DATE]. The resident was also transferred from the facility to the hospital on August 30, 2022 . The resident was readmitted to the facility on [DATE]. A review of Resident 36's clinical record revealed the resident was transferred to the hospital on September 21, 2022, and returned to the facility on [DATE]. A review of Resident 249's clinical record revealed the resident was transferred to the hospital on September 9, 2022, and did not return to the facility. Further review of the above mentioned clinical records failed to provide documented evidence of the information communicated to the receiving health care facility upon transfer or discharge from the facility included care plans goals sent to the receiving health care facility. Interview with the Nursing Home Administrator on December 2, 2022, at 2:00 PM, regarding information communicated to the receiving health care facility upon transfer or discharge from the facility, the facility was unable to provide evidence of the documentation that care plans goals are sent with each resident to the receiving facility. 28 Pa. Code 201.29(f)(g)(h) Resident rights 28 Pa. Code 211.5 (f) Clinical records

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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 clinical record review and staff interview, it was determined the facility failed to provide written notice of facility initiated transfers to the resident and the residents' representative for six out of six residents reviewed (Resident 54, 76, 77, 93, 36, and 249). Findings include: A review of the clinical record revealed that Resident 54 was transferred to the hospital on November 7, 2022. A review of Resident 76's clinical record revealed transfer to the hospital on August 3, 2022 and returned to the facility on [DATE] . A review of Resident 77's clinical record revealed the resident was transferred to the hospital on May 4, 2022. The resident was readmitted to the facility on [DATE]. The resident was also transferred to the hospital on August 30, 2022 . The resident was readmitted to the facility on [DATE]. A review of the clinical record revealed that Resident 93 was transferred to the hospital on September 23, 2022. A review of the clinical record revealed that Resident 36 was transferred to the hospital on September 21, 2022 and returned to the facility on [DATE]. A review of the clinical record revealed that Resident 249 was transferred to the hospital on September 9, 2022 and did not return to the facility. Further review of the clinical records of the above residents revealed no documented evidence that written notice was provided to these residents and the resident representatives regarding the transfers that included the required contents: reason for the transfer, effective date of the transfer, location to which the resident was transferred to, contact and address information for the Office of the State Long-Term Care Ombudsman, and if applicable, information for the agency responsible for the protection and advocacy of individuals with developmental disabilities. Interview with Nursing Home Administrator on December 2, 2022 at approximately 2:00 PM, confirmed the facility had no documented evidence of written notices to the resident and the resident's representative of the facility initiated transfers. 28 Pa. Code 201.29(i) 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 clinical record review 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 for six of six residents reviewed (Residents 36, 54, 76, 77, 93 and 249). The findings include: A review of Resident 36's clinical record revealed that the resident was transferred from the facility on September 21, 2022, and returned to the facility on [DATE]. A review of Resident 54's clinical record revealed that the resident was transferred to the hospital on November 7, 2022. A review of Resident 76's clinical record revealed a hospitalization on [DATE] and returned to the facility on [DATE] . A review of Resident 77's clinical record revealed the resident was transferred from the facility and admitted to the hospital on May 4, 2022. The resident was readmitted to the facility on [DATE]. The resident was also transferred from the facility to the hospital on August 30, 2022 . The resident was readmitted to the facility on [DATE]. A review of Resident 93's clinical record revealed that the resident was transferred from the facility on September 23, 2022 . A review of Resident 249's clinical record revealed that the resident was transferred from the facility on September 9, 2022 and did not return to the facility. The facility was unable to provide documented evidence, by the end of the survey on December 2, 2022, 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 and the cost of holding a bed. The lack of documented evidence of the provision of written notice of the facility's bed hold policy upon hospital transfer of the above residents, was confirmed by the Nursing Home Administrator during an interview on December 2, 2022. 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 - Few	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 that the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of three residents out of 19 sampled (Resident 57, 76, 86) residents. Findings include: A review of Resident 57's quarterly MDS assessment dated [DATE], and significant change MDS assessment dated [DATE], revealed in Section H0300, Urinary Continence that the resident was occasionally incontinent. The resident's Documentation Survey Report for the months of March 2022, May 2022 and June 2022 indicated that the resident was only continent three times during the March 30, 2022 lookback period, and only continent once during the May 31, 2022 to June 6, 2022, MDS assessment look back periods. The March 30, 2022 and June 6, 2022 quarterly MDS assessments were inaccurate with respect to the resident's urinary continence status. A review of Resident 76's annual MDS assessment dated [DATE], revealed in Section H0300, Urinary Continence that the resident was occasionally incontinent. The resident's Documentation Survey Report for June 2022 indicated that the resident was only continent twice during the June 2022 MDS assessment lookback period. The resident's June 22, 2022 annual MDS was inaccurate with respect to the resident's urinary continency. A review of Resident 86's quarterly MDS assessment dated [DATE], revealed in Section K0300 that the resident did have a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. A review of the resident's clinical record revealed that the resident's weight was recorded on June 16, 2022, as 90.8 pounds, on July 3, 2022, as 94.8 pounds, August 1, 2022, as 100.8 pounds and September 5, 2022, as 101.8 pounds, an increase in weight. Interview with the Nursing Home Administrator on November 30, 2022, confirmed the above MDS inaccuracies. 28 Pa. Code 211.5(g)(h) Clinical records. 28 Pa. Code 211.12(c)(d) (1)(3)(5) Nursing Services

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records and select resident incident/accident reports and staff interview, it was determined that the facility failed to consistently provide adequate supervision and effective safety measures to prevent falls for a resident identified at high risk for falls with known restless and unsafe behaviors resulting in a fall with serious injuries, a fractured hip and ribs, for one resident out of 19 sampled (Resident 249). Findings include: A review of the clinical record revealed that Resident 249 was admitted to the facility on [DATE], with diagnoses to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and history of falling. A review of a fall risk evaluation dated August 7, 2022, revealed the resident was assessed at a high risk for falling. A review of an Admission Minimum Data Set Assessment (MDS - a federally mandated standardized assessment completed at specific times to identify resident care needs) dated August 10, 2022, revealed that the resident was moderately cognitively impaired and required extensive assistance of two staff for bed mobility, transferring, and toileting. The resident required supervision of one staff member when moving about on the nursing unit according to the MDS. The resident's care plan, initially dated August 4, 2022, noted the resident's problem of being at risk for falls related to impaired mobility. The resident's goal was to minimize injuries related to falls. Interventions planned were to provide assistance with transfers, have the bed in the lowest position, and have commonly used items in reach. A progress note dated August 6, 2022, at 12:43 AM revealed that the resident was found on the floor of his room, seated three feet away from his wheelchair. The resident stated at that time he wanted to walk. A review of an incident report dated August 7, 2022, at 12:10 AM, revealed the resident was found on the floor sitting on his buttocks three feet away from his wheelchair. The resident at that time stated he wanted to walk. No injuries were noted. A new intervention of a clip alarm check for functioning and placement was added to the resident's plan of care on August 7, 2022. A review of a skilled note dated August 9, 2022, at 12:33 PM, revealed that the resident was restless and balance was unsteady. A nursing note dated August 13, 2022, at 5:42 AM, indicated that the resident was attempting to self-transfer himself out of bed at 4:10 AM. The resident was screaming and yelling for his wife that he needed to leave. The resident was assisted in his wheelchair to the nurse's station. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing note dated August 16, 2022, at 7:55 AM, revealed that the resident was restless and awake at times. A review of a skilled note dated August 18, 2022, at 8:23 PM, revealed that the resident was anxious and fidgety. A review of a skilled note dated August 19, 2022, at 8:23 PM, revealed that the resident was a safety concern due to his unsteady gait. A nursing note dated August 20, 2022, at 2:28 AM, revealed that the resident was having difficulty sleeping and was sitting on the side of the bed. The resident would reposition to laying and then sitting numerous times. The resident had increased confusion according to this nursing documentation. On August 20, 2022, at 6:25 AM, the resident had difficulty sleeping all shift. The resident was confused and unable to follow directions. The resident was attempting to get out of bed and out of his wheelchair without assistance multiple times. Nursing noted on August 20, 2022, at 1:35 PM, that the resident's safety remained a concern due to unsafe self-transfers and being a fall risk. A nursing note dated August 21, 2022, at 3:03 AM, revealed that the resident was very restless throughout the night. The resident appeared to be unable to relax and continuously moving from lying position to sitting position with legs dangling on the side of the bed. The resident was brought out to the nurse's station in his wheelchair, but remained restless and attempted to stand independently. Review of a nursing note dated August 22, 2022, at 2:51 AM, revealed that the resident was restless and anxious at times throughout the night. A nursing note dated August 22, 2022, at 11:05 AM, indicated that the resident was self-propelling in his wheelchair on the unit was confused and forgetful. Review of a skilled note dated August 22, 2022, at 9:20 PM, revealed the resident was anxious and fidgety. A review of a nursing note dated August 26, 2022, at 6:22 AM, indicated the resident was awake all night in his wheelchair. On August 26, 2022, at 9:54 PM, nursing noted that the resident has safety concerns due to him trying to get up by himself. Review of a skilled note dated August 29, 2022, at 2:17 PM revealed that the resident's balance was unsteady and displayed unsafe self-transferring. A review of a nursing note dated August 30, 2022, at 3:30 AM, indicated that the resident was awake all night trying to self-transfer. The resident was consistently sitting on the very edge of the bed asking what time it was every 15 minutes. A note entered at 3:33 AM revealed that the resident was being monitored at the nurse's station as a safety precaution due to the resident being a fall risk and attempting to self-transfer. On August 30, 2022, at 12:03 PM, nursing noted that the the resident's safety was a concern due to self-transferring. Review of a skilled note dated August 31, 2022, at 6:43 PM, revealed the resident was still a safety concern due to self-transferring. A review of a nursing note dated September 4, 2022, at 12:40 AM revealed that the resident will only lay down for a short period of time and was mostly in his wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Skilled notes dated September 6, 2022, at 2:01 PM, September 7, 2022, at 9:05 AM and September 8, 2022, at 9:08 AM revealed the resident was restless, anxious, and fidgety and his safety was a concern due to attempts to self-transfer and risk for falls. A review of a progress note dated September 8, 2022, at 11:52 PM, indicated the resident was sitting in front of the nurse's station and is verbally yelling out. A review of a nursing note dated September 9, 2022, at 12:45 AM, revealed the resident was sitting at the nurse's station constantly self-rising and subsequently fell near the nurse's station The resident hit his head. A laceration was noted to the left part of the forehead with a large hematoma. A review of the incident and accident report dated September 9, 2022, at 1:11 AM, revealed that at 12:45 AM the resident was found on the floor lying near the nurse's station on his left side with his knees bent. The resident was found next to his wheelchair with the alarm sounding. Staff assisted the resident back to his wheelchair. He had a red area to the left side of the head and pain to his left leg, head and buttocks. He was transferred to the hospital for evaluation. A review of hospital records dated September 9, 2022, revealed that the resident sustained a fracture of the left and right femoral neck and a fracture of the right lateral 8th rib. A review of a witness statement from Employee 2 NA (nurse aide) dated September 9, 2022, revealed the employee stated that it was just her and another nurse on the floor to care for the residents at the time of the resident's fall on September 9, 2022. Employee 2 stated that she and the nurse were helping put another resident in bed when she heard an alarm sounding alerting staff that Resident 249 had fallen out of the wheelchair. A review of a witness statement from Employee 3 LPN (licensed Practical Nurse) dated September 9, 2022, revealed that Employee 3 stated that she was in a resident's room providing care with Employee 2, a nurse aide. When Employee 3 left that other resident's room, she noticed Resident 249 on the floor next to his wheelchair in front of the nurse's station with the alarm going off. Employee 3 stated that there was only one other nursing staff member besides herself on the nursing unit that night. Employee 3 stated that Resident 249 had been awake and confused constantly that night and required staff assistance. The facility failed to review and revise the adequacy of the resident's fall prevention care plan in response to the resident's ongoing restlessness and repeated attempts at unsafe self-transferring. The resident's care plan also failed to identify the resident's behaviors of being awake frequently during the night and needing increased supervision due to unsafe and restless behaviors. On the night of the resident's fall on September 9, 2022, staff brought the resident to the nurse's station for supervision for restless behaviors and unsafe behaviors. However, due to the staffing levels the resident was left unattended at the nurse's station, while staff were in a resident room providing care to another resident. Resident 249 fell while unsupervised and sustained fractures. An interview with the Nursing Home Administrator on December 2, 2022, at approximately 2:00 PM confirmed the facility failed to provide effective safety interventions and sufficient and timely staff supervision to Resident 249 to prevent falls and injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Refer F725 28 Pa. Code 211.11(d) Resident care plan 28 Pa Code 211.12(a)(d)(5) Nursing services 28 Pa Code 211.12(c) Nursing services 28 Pa Code 211.12(d)(1) Nursing services 28 Pa Code 211.12(d)(3) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26228 Based on review of clinical records and staff interview, it was determined that the facility failed to thoroughly assess and evaluate bladder function and implement individualized interventions to restore or maintain bladder function to the extent possible for one out of two sampled residents (Residents 76). Findings include: Review of Resident 76's clinical record indicated that the resident was admitted to the facility on [DATE], and had diagnoses that included dementia, and depression. An annual Minimum Data Set Assessments (MDS -a federally mandated standardized assessment completed at specific intervals to define resident care needs) dated March 23, 2022, and June 22, 2022, indicated that the resident was severely cognitively impaired, dependent on staff for activities of daily living (ADLs- the basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring and repositioning) and was occasionally incontinent of bowel and bladder. Resident 76's Admission/Re-admission Evaluation dated August 8, 2022, indicated that the resident was incontinent of bowel and bladder. A 3-day bowel and bladder record was to be conducted every hour while awake and every two hours from 10:00 p.m. to 6:00 a.m. The Bowel and Bladder Evaluation dated August 12, 2022, indicated the resident did not display any identifiable voiding pattern and the facility initiated incontinence care and comfort. However, a review of the resident's 3-day bowel and bladder record from August 9, 2022, to August 11, 2022, did reveal patterns of incontinence exhibited by the resident at 4:00 a.m. 6:00 a.m. 7:00 a.m. 11:00 a. m. 12:00 p.m. from 2:00 p.m. every hour to 10:00 p.m., which the facility failed to identify. The resident's Quarterly MDS assessment dated [DATE], indicated that the resident was now totally incontinent of bowel and bladder. The resident's MDS Assessments dated March 23, 2022, through June 22, 2022, indicated that the resident was occasionally incontinent of bladder. However, there was no evidence of individualized interventions to restore normal bladder function to the extent practicable prior to the resident becoming totally incontinent when assessed on August 14, 2022. Review of Resident 76's plan of care from admission to the time of the survey revealed that the resident's bladder and/or bowel incontinence was not addressed. The facility failed to thoroughly assess and evaluate bladder function and implement individualized interventions to restore or maintain bladder function to the extent possible for Resident 76. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on December 2, 2022 at 11:30 a.m. verified that the facility failed to identify Resident 76's patterns of incontinence and plan individualized care accordingly. The NHA confirmed Resident 76 was placed on incontinence care without prior attempts to improve continence. 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(c)(d) Resident care plan

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26228 Based on a review of clinical records and select facility policy and staff interview, it was determined that the facility failed to consistently monitor weights for two residents out of nine residents reviewed (Resident 12 and 75) and timely implement nutritional support to meet the nutritional needs and prevent weight loss for two residents out of nine sampled (Residents 35 and 57). Findings include: Review of the current facility policy Weight Assessment and Intervention provided during the survey of December 2, 2022, indicated that the multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. The nursing staff will measure the resident weights on admission and weekly for four weeks thereafter. If no weight concerns are noted a this point, weights will be measured monthly thereafter. The weights will be recorded in the resident's electronic medical records. Any weight change of 5% or more since the last weight assessment will be addressed by the Dietitian. The Dietitian will review the resident weight record to follow individual weight trends over time. negative trends will be evaluated by the interdisciplinary team whether or not the criteria for significant weight change has been met. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss= (usual weight- actual weight)/ (usual weight) x 100]: a. 1 month- 5% weight loss is significant; greater than 5% is severe b. 3 months- 7.5% weight loss is significant; greater than 7.5% is severe c. 6 months- 10% weight loss is significant; greater than 10% is severe A review of the clinical record revealed that Resident 12 was admitted to the facility on [DATE], with diagnoses to include protein calorie malnutrition, congestive heart failure and dementia. A review Resident 12's comprehensive care plan-initiated September 15, 2022, revealed a focus area of nutritional status as evidenced by actual/potential weight loss/gain related to PCM (Protein Calorie Malnutrition), obesity, dementia, varied meal intakes, resident reported weight loss with a goal of will not experience a significant change in weight through next review. Interventions planned included to honor food preferences, provide diet/supplements per orders, and weights as ordered. An admission Nutritional Risk Evaluation dated September 15, 2022, indicated that Resident 12's weight was stable and the admission weight which was documented was 185.4 which was obtained from the chart and hospital records. The resident reported that her normal weight was 200 pounds and she lost weight. Review of Resident 12's weights revealed on October 6, 2022, the resident weighed 156.2 pounds, which was a 29.2-pound weight loss or 15.7 % weight loss in 22 days. There was no documented evidence that physician was made aware of the significant weight loss (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Nutrition Note dated October 12, 2022, at 21:18 (9:18 PM) revealed that the resident had a significant weight loss and a reweight was taken on October 12, 2022 to confirm weight loss. The note indicated that weekly weights will be added for weight monitoring. A Nutrition Note dated October 28, 2022 at 21:29 (9:29 PM) revealed that resident continues to refuse weights. There was no documented evidence, other than the nutrition note dated October 28, 2022, that the resident was refusing to be weighed or that the facility had addressed these refusals on the resident's care plan with measures to promote compliance with weight monitoring. Following surveyor inquiry during the survey of December 2, 2022, the Nursing Home Administrator provided documentation dated October 27, 2022, that Resident 12 had refused to be weighed on that date. However, further review of this documentation revealed that the facility staff had documented weight as NA (not applicable) for the resident's weights on October 2, 2022, and October 3, 2022. A review of the clinical record revealed that Resident 75 was admitted to the facility on [DATE], with diagnoses to include osteomyelitis, type 2 diabetes mellitus, and hyperlipidemia. A review of Resident 75's weight record revealed no documented evidence that the resident's weight was obtained during September 2022 or October of 2022. Review of Resident 35's clinical record revealed that the resident was admitted to the facility on [DATE], and had diagnoses of anxiety and weakness. The resident's weight record revealed the following recorded weight upon admission was on October 15, 2022 was 110.8 lbs. Nutritional Evaluation Note dated October 17, 2022, at 8:28 p.m. indicated that the resident had a weight loss while hospitalized prior to admission to the facility. The percent of weight change was noted at 7.5% from hospital stay to admission. The plan was to add 2.0 Cal supplement twice daily to promote healthy weight gain/stabilization. Review of Medication Administration Record (MAR) for October 2022 indicated that the 2.0 Cal supplement twice daily was not initiated and provided ot the resident until October 24, 2022, at 5:00 p.m. Interview with the Administrator on December 2, 2022, at 10:15 a.m. verified that the nutritional supplement was not initiated promptly when planned on October 17, 2022, after the Nutritional Evaluation, but rather started on October 24, 2022, at 5:00 p.m. Review of Resident 57's clinical record revealed that the resident was admitted to the facility on [DATE], and had a diagnosis of dementia and depression. A review of the resident's weight record that the resident had a 12.46% 17.6 lb significant weight loss from March 8, 2022, to September 1, 2022. The resident's weight decreased from 141.2 lbs to 123.6 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Nutrition Note dated April 8, 2022, at 11:59 a.m. indicated that the weights were reviewed, recent weight of 135 pounds, which has been a 14 pound (9.4%) weight loss in the last 3 months. It also indicated the resident receives 2.0 Cal supplement 120 milliliters (mL) twice daily with intakes 100% and health shakes with lunch and dinner. A Nutrition Note dated May 10, 2022 at 1:20 p.m. indicated that on November 4, 2021 the resident weighed 155.6 pounds and current weight is 131.0 pounds indicating a 24.6 pound and 15.8% significant weight loss. The entry noted that the resident currently receives 2.0 Cal supplement 120 mL twice daily and health shakes with lunch and dinner. The plan was to try increasing the health shakes from twice daily to three times daily due to significant weight decline in 6 months. Review of the resident's May 2022 MAR revealed that on May 10, 2022, the health shake was increased from twice daily to three times daily. However, there was no evidence that the health shake was provided to the resident from May 10, 2022, through May 31, 2022. Review of the resident's June 2022, July 2022, August 2022 and September 2022 MARs revealed no indication that the health shake supplements were given to the resident from June 1, 2022, through September 21, 2022. A Nutrition Note dated August 3, 2022 at 9:34 p.m. identified a significant weight loss and also indicated the resident was receiving 2.0 Cal supplement in place twice daily, with good intakes. The entry noted Will increase to TID to prevent further decline. The Nutrition Note failed to identify that the resident was also to be receiving health shakes three times daily. The note failed to identify that the health shake supplementation was not being provided and evaluate the resident's consumption. Interview with the Administrator on December 2, 2022 at 10:15 a.m. verified that the Resident 35 and 57 did not receive nutritional supplementation as planned. 28 Pa Code 211.6(c)(d) Dietary services. 28 Pa Code 211.10 (a)(c)(d) Resident care policies. 28 Pa Code 211.12 (a)(c)(d)(3)(5)Nursing services.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records, select incident and accident reports, and nurse staffing levels and staff interview it was determined that the facility failed to provide sufficient nursing staff to meet the individual care needs and promote safety of one resident out of 19 sampled (Resident 249) Findings include: A review of the clinical record revealed that Resident 249 was admitted to the facility on [DATE], with diagnoses to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and history of falling. A review of the resident's plan of care for the resident's problem of being at risk for falls related to impaired mobility, revised by the facility on August 7, 2022, indicated that the established goal was to minimize injuries related to falls. Interventions were to provide assistance with transfers and enforce wheelchair safety. Progress notes dated August 6, 2022, at 12:43 AM revealed that the resident was found on the floor sitting three feet away from his wheelchair. The resident stated at that time he wanted to walk. A review of a nursing note dated August 13, 2022, at 5:42 AM, indicated that the resident was attempting to self-transfer himself out of bed at 4:10 AM. The resident was screaming and yelling for his wife that he needed to leave. The resident was assisted into his wheelchair and brought to the nurse's station. Review of a nursing note dated August 20, 2022, at 2:28 AM, revealed that the resident was having difficulty sleeping, and was sitting on the side of his bed. The resident would reposition to laying, and then back to sitting numerous times. The resident had increased confusion. A review of a progress note dated August 20, 2022, at 6:25 AM, revealed that the resident had difficulty sleeping all shift. The resident was confused and unable to follow directions. The resident was attempting to get out of bed and his wheelchair without assistance multiple times. Review of a progress note dated August 20, 2022, at 1:35 PM, indicated resident is a safety concern due to unsafe self-transfers and being a fall risk. A review of a nursing note dated August 21, 2022, at 3:03 AM, revealed the resident was very restless throughout the night. The resident appeared to be unable to relax and continuously moving from lying position to sitting position with legs dangling on the side of the bed. The resident was brought out to the nurse's station in his wheelchair but remained restless and attempted to stand independently. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing note dated August 22, 2022, at 2:51 AM, revealed the resident was restless and anxious at times throughout the night. A review of a nursing note dated August 30, 2022, at 3:30 AM, indicated the resident was awake all night trying to self-transfer. The resident was consistently sitting on the very edge of the bed asking what time it was every 15 minutes. Further a note entered at 3:33 AM revealed that the resident was being monitored at the nurse's station as a safety precaution due to the resident being a fall risk and attempting to self-transfer. The plan of care failed to identify the resident's safety concerns for unsafe self-transferring. Further the care plan failed to identify the resident's behaviors of being awake all night and needing supervision due to this unsafe and restless behaviors. A review of an incident and accident report dated September 9, 2022, at 1:11 AM, revealed that at 12:45 AM on September 9, 2022, the resident was found on the floor lying on his left side with his knees bent near the nurses station where he had been placed for supervision. The resident was found next to his wheelchair with the alarm sounding. Staff assisted the resident back to his wheelchair and he was noted to have a red area to the left side of the head and pain to his left leg head and buttocks. The resident was transferred to the hospital and diagnosed with hip and rib fractures. A witness statement from Employee 2, NA (nurse aide), dated September 9, 2022, revealed that Employee 2 stated it was just her and another nurse on the floor to care for the residents at the time Resident 249 fell . Employee 2 stated that she and nurse (Employee 3, LPN) we're helping put another resident in bed when she heard an alarm sounding. Resident 249 had fallen out of the wheelchair while at the nurse's station unsupervised. A review of a witness statement from Employee 3 LPN (licensed Practical Nurse) dated September 9, 2022, revealed that Employee 3 stated she was in a resident's room providing care to a resident with Employee 2. When Employee 3 exited that resident's room, she noticed Resident 249 on the floor next to his wheelchair in front of the nurse's station with the alarm going off. Employee 3 stated that there was only one other nursing staff member besides herself on the nursing unit that night. Employee 3 stated that Resident 249 was awake and confused constantly at night and required staff assistance. A review of the facility's nurse staffing ratio for September 8, 2022, going into September 9, 2022, for the 11 PM-7 AM shift, confirmed that there were 45 residents on the third floor nursing where Resident 249 resided and two nursing staff responsible for caring for the residents on this unit. Resident 249 was brought to the nurse's station for supervision but left unattended and fell sustaining injuries while nursing staff were in another resident's room providing resident care. An interview with the Nursing Home Administrator on December 2, 2022, at approximately 2:00 PM confirmed failed to provide sufficient nursing staff to meet the individual safety needs of Resident 249. Refer F689 28 Pa. Code 211.12 (a)(c)(d)(4)(5) Nursing Services.

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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** 41581 Based on 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 two out of 19 residents (Resident 249 and 70). Findings include: A review of the clinical record revealed that Resident 249 was admitted to the facility on [DATE], with diagnoses to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning). An Admission MDS Assessment (Minimum Data Set, an assessment completed periodically to plan resident care) dated August 10, 2022, revealed that Resident 249 was moderately cognitively impaired. A review of Resident 249's nursing progress notes from August 2022 until discharge on [DATE], revealed that the resident exhibited behaviors of restlessness, trying to get out of bed without staff assistance, unsafe self-transferring from the bed and wheelchair, anxiousness, fidgety behavior, was frequently awake all night, confused, yelling cursing, wandering, and accusing residents of stealing his property. Further it was noted the resident had two falls in the facility from August 2022 until September 2022 due to these restless behaviors. The resident's care plan to address his cognitive loss related to dementia failed to address the specific behaviors exhibited by the resident. There was no documented evidence that the facility had developed individualized person-centered interventions to address the resident's behavior utilizing individualized, non-pharmacological approaches to care, such as purposeful and meaningful activities that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being. A review of the clinical record revealed that Resident 70 was admitted to the facility on [DATE], with diagnoses to include dementia. A Quarterly MDS dated [DATE], revealed that Resident 70 was severely cognitively impaired. A review of the resident's current plan of care no documented evidence that the facility had developed individualized person-centered dementia care plan to address the resident's needs for dementia care to improve the resident's quality of life. An interview with NHA (Nursing Home Administrator) on December 2, 2022, at approximately 2:00 PM confirmed the facility failed to develop and implement an individualized person-centered plan to address the residents' dementia-related behavioral symptoms. 28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.11(d) Resident care plan

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 26228 Based on a review of clinical records, select facility policy, investigative reports and information submitted by the facility and staff interview, it was determined that the facility failed to implement established procedures for disposal/disposition of controlled medications for two of three residents reviewed (Residents CR1 and CR2). Finding include: Review of the current facility policy for Disposal of Controlled Substances provided during the survey of December 2, 2022, revealed that the disposal and/or destruction of controlled substances must be completed at the facility. Controlled substances cannot be returned to the pharmacy for destruction. Generally all states require destruction to be conducted in the presence of two authorized professionals (in Pennsylvania either two licensed nurses or a nurse and pharmacist). Review of information dated November 7, 2022, submitted by the facility and a facility investigation revealed that the Director of Nursing (DON) approached Employee 4 on November 3, 2022 at approximately 4:15 p.m. and asked Employee 4 for the controlled medications for Residents CR1 and CR2 because the residents were no longer in the facility and likely not returning. The information indicated that Employee 4 had signed the Controlled Drug Record for the disposition of Resident CR1 and CR2's controlled drugs as a second witness, but she did not witness the actual destruction of the medications. Employee 4 indicated that she saw the DON take the residents' controlled medications and walk down to her office. Interview with the DON on November 8, 2022 at approximately 8:30 a.m. the DON confirmed that she was aware of facility policy on disposal of controlled substances and confirmed she took the controlled drugs from Employee 4 and Employee 4 signed the controlled drug records. The DON stated that she took the medications to the medication room, popped out the pills from the blister packs and put them in the drug buster to destroy the medications. Interview with the Administrator on November 30, 2022 at 9:30 a.m. confirmed that the DON did not follow facility policy for disposal of controlled substances. 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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of select facility policy and clinical records, and staff interviews, it was determined that the facility failed to ensure that the ordering practitioner was promptly notified and acted upon abnormal laboratory results for one of 19 residents reviewed (Resident 2) to ensure that the resident received timely treatment and services. Findings include: A review of facility policy entitled Lab and Diagnostic Test Results Clinical Protocol last reviewed by the facility March 24, 2022, revealed a subsection entitled Physician Responses. This section indicated a physician should respond in a timely fashion based upon the resident situation regarding a laboratory test result requiring immediate notification or by the end of the next office day to a non-emergency message. If the attending or covering physician does not respond to immediate notification the nursing staff should contact the medical director for assistance. A review of the clinical record revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses to include chronic kidney disease and heart failure. A review of progress notes revealed that on November 14, 2022, at 12:29 AM a urine sample was obtained. The specimen was labeled and the laboratory was called for the specimen to be picked up according to the entry. A review of a progress note dated November 17, 2022, at 6:27 AM, staff assessed the resident's urine output. The resident was observed with a purple/dark gray urine in her catheter bag. A urine specimen was taken from the top of the Foley catheter tubing and was observed to be cloudy and yellow. A laboratory result report dated November 18, 2022, that was faxed to the facility at 1:52 AM, revealed that Resident 2 had multiple abnormal laboratory results as follows: Urinalysis (test to the urine) Urine Protein value was a trace (normal results Negative) Urine Esterase (type of white blood cells) value was large (normal results Negative) Urine WBC (white blood cells) value was 10-19 (normal results 0-2) Urine Bacteria value was 101-150 (normal results 0-25) Urine Hyaline (cluster of urinary particles) value was 1-4 (normal results none) Urine Culture Greater than 100,000 colonies per milliliter of Morganella Morganii (bacteria) (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10,000 to 100,000 colonies per milliliter of Proteus Mirabilis (bacteria). Further review of the laboratory report revealed that the facility faxed the results to the physician on November 18, 2022, at 2:10 AM. A review of a nursing note dated November 18, 2022, at 1:52 AM, indicated the resident's urinalysis and culture and sensitivity results were received from the laboratory and faxed to the physician and staff were awaiting new orders to treat the reported urinary tract infection. There was no documented evidence in the clinical record to indicate that the physician acknowledged receipt/awareness of the abnormal laboratory values on November 18, 2022. A review of a progress note dated November 21, 2022, at 8:09 AM, three days after the facility received the abnormal laboratory results for Resident 2 it was noted that the physician was made aware of the laboratory results and a new order was received for Cefuroxime (antibiotic) 250 MG by mouth twice a day for seven days. Interview with the Nursing Home Administrator on December 2, 2022, at approximately 2:00 PM confirmed the facility failed to ensure the physician was promptly notified and responded to Resident 2's abnormal laboratory results to prevent delay in resident treatment. 28 Pa. Code 211.2 (a) Physician services 28 Pa. Code 211.12 (a)(d)(3)(5) Nursing services.

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	12/02/2022

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 26228 Based on observation, a review of facility's planned menus and resident and staff interview it was determined that the facility failed to reasonable accommodate individual food preferences to the extent possible to increase resident satisfaction with meals for three residents out of 19 sampled (Residents 7, 52 and 58). Findings include: During a group interview on November 30, 2022, at 10:00 AM with residents, which included Residents 7 and 52, the residents reported that at times the facility failed to serves foods consistent with their identified food preferences on their meal tray tickets. Review of the facility menu for lunch on Wednesday November 30, 2022, revealed that an apple baked pork chop, buttered red potatoes, and seasoned asparagus was planned for the menu for residents. Observation of the lunch meal on November 30, 2022 at 11:50 a.m. revealed that Resident 58's meal tray ticket indicated that the resident was to receive an apple baked pork chop, an American cheese sandwich on white bread, buttered red potatoes, seasoned asparagus, a dinner roll, whole milk and coffee. Observation of the meal provided to Resident 58 there was no American cheese sandwich on the tray. Further observation at 12:05 p.m. on November 30, 2022, of Resident 52's meal tray ticket indicated that the resident was to receive parmesan cod, buttered red potatoes, seasoned asparagus, dinner roll, chocolate pudding, 2% milk and coffee. Observation of the meal served to Resident 52 revealed there was no parmesan cod on the resident's meal tray. There was a hamburger on the tray in place of the cod. Interview with the resident at 12:10 p.m. revealed that she stated that she did not order a hamburger for the lunch meal. Observation at 12:20 p.m. on November 30, 2022, of Resident 7's meal tray ticket indicated that the resident was to receive a ground baked pork chop, pork gravy, buttered red potatoes, seasoned asparagus, dinner roll, chocolate pudding, whole milk, Hot tea and diet cola. Observation of the meal served to Resident 7 revealed that he received the ground baked pork chop, pork gravy, buttered red potatoes, seasoned asparagus, whole milk and dinner roll, however he received vanilla pudding, iced tea, and hot coffee instead of the chocolate pudding, Hot tea and diet cola on the meal tray ticket. During interview with Resident 7 at 12:25 p.m. he confirmed that he did not receive what he had ordered at this lunch meal. Interview with Employee 1 (certified dietary manager) on November 30, 2022, at approximately 1:30 p.m. he confirmed that Resident 58 did not receive an American cheese sandwich on the tray, Resident 52 received a hamburger instead of the planned cod, and Resident 7 received vanilla pudding, iced tea, and hot coffee instead of the chocolate pudding, Hot tea and diet cola as noted on the meal tray ticket. 28 Pa. Code 211.6 (c) Dietary services (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.29(a)(i)(j) Resident rights

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41581 Based on review of select facility policies, the facility's infection control tracking log and staff interview, it was determined that the facility failed to maintain and implement a comprehensive program to monitor and prevent infections in the facility. Findings included: A review of facility policy entitled Infection Prevention and Control Program last reviewed March 24, 2022, indicated that the infection prevention and control program is developed to address the facility specific infection control needs and requirements identified. Further it is indicated that data gathered during surveillance is used to oversee infections and spot trends. The infection preventionist collects data from the nursing units categorizes each infection by body site and records the absolute number of infections. A review of the facility's infection control data provided at the time of the survey revealed that the facility's infection control program failed to reflect an operational system to monitor and investigate causes of infection and manner of spread. There was no evidence of a system, which enabled the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. A review of facility infection control logs for June 2022 through December 2022 revealed that the facility did not track any infections for the month July 2022 and had not yet started tracking infections for the month of December 2022 as of the time of the survey ending December 2, 2022. A review of clinical record indicated that Resident 70 was treated for was treated for cellulitis in the month of September 2022. Resident 36 was treated for a urinary tract infection in the month of November 2022 Resident 2 was treated for a urinary tract infection in the month of November 2022. The facility's infection control logs failed to identify these infections. There was also no documented evidence that the facility reviewed these infections to identify the potential need for intervention with staff and residents to deter similar infections. There was no indication that the limited data that was compiled was then evaluated to determine what could be done to prevent the spread or recurrence of infection. Interview with the Infection Preventionist on December 2, 2022, at 10:30 AM confirmed that the facility infection control tracking logs were incomplete and that the facility was unable to demonstrate a fully functioning comprehensive program to monitor and prevent infections. 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing services. 28 Pa. Code 211.10(a)(d) Resident care policies

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26228 Based on review of clinical records and staff interview, it was determined that the facility failed to offer and/or provide the pneumococcal and/or influenza immunization to four of 18 residents reviewed (Residents 5, 35, 57, and 77) if eligible. Findings include: A review of the clinical record revealed that Resident 5 was admitted to the facility on [DATE]. A review of the clinical record revealed that Resident 35 was admitted to the facility on [DATE]. A review of the clinical record revealed that Resident 57 was admitted to the facility on [DATE]. A review of the clinical record revealed that Resident 77 was admitted to the facility on [DATE]. At the time of the survey ending December 2, 2022, the facility could not provide documentation that the pneumococcal and/or influenza immunization was offered to the above residents. Interview with the Administrator on December 2, 2022, at approximately 10:30 a.m. confirmed that there was no evidence that Residents 5 and 35 were offered and/or provided the pneumococcal and influenza immunization, and Residents 57 and 77 were offered and/or provided the pneumococcal immunization. 28 Pa Code 211.12 (a)(c)(d)(1)(5) Nursing services 28 Pa Code 211.5 (f) Clinical records.

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Report COVID19 data to residents and families. 41581 Based on review of information provided by the facility and staff interview, it was determined that the facility failed to ensure that residents representatives and families were timely informed of cumulative, confirmed, and suspected COVID-19 infections in the facility. Findings include: Interview with the Nursing Home Administrator, on November 29, 2022, at 8:48 AM revealed that the facility notifies residents representatives and families of confirmed of suspected COVID-19 within the facility via a telephone call from facility staff and will be documented in the residents' clinical records that the residents and families are made aware. Review of facility line listing revealed a resident tested positive for COVID-19 on October 31, 2022, and facility wide testing was initiated. Further review of the facility line listing revealed another resident tested positive for COVID-19 on November 9, 2022. Upon clinical record reviews there was no documented evidence that families and residents were timely informed of cumulative, confirmed, or suspected COVID-19 infections in the facility. Interview with the Nursing Home Administrator on December 2, 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