STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395058	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rest Haven-York	1050 South George Street York, PA 17403

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879 Based on policy review, observations, clinical record reviews, facility document review, and staff interviews, it was determined that the facility failed to protect the residents' right to privacy for three of three residents reviewed for the use of video/audio monitoring (Residents 16, 27, and 65). Findings include: Review of facility policy, titled Resident Rights, not dated, revealed it stated: 1. The Resident has the right to be informed of their rights and of all rules and regulations governing resident conduct and responsibilities both orally and in writing prior to or upon their admission or as appropriate during their stay. 2. The Resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 3. The Resident has the right to exercise their rights as a Resident of Rest Haven - [NAME] and as a citizen of the United States. 4. If the Resident is not capable of exercising their rights, a court-appointed person or Power of Attorney may exercise their rights. A Resident who has not been adjudged incompetent has the right to designate a representative and the representative may exercise the Resident's rights to the extent provided by the law . 11. The Resident has the right to choose a personal attending physician and to be [NAME] informed by the physician or other professional in advance about the risks and benefits of proposed care and treatment, alternatives to proposed care and treatment, and to participate in planning care and treatment . 24. The Resident has the right to privacy and confidentiality with their written, electronic, and telephone communication and personal visits . 31. The Resident has the right to an environment that promotes maintenance or enhancement of quality of life including respect, dignity, and privacy during personal care . (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 27's clinical record on January 29, 2025, revealed diagnoses that included chronic kidney disease stage three (moderately decreased ability of the kidneys to filter toxins from the blood) and history of cerebral infarction (stroke - sudden loss of blood, or bleeding in the brain that causes damage to the brain cells, which can result in physical and mental deficits and/or death). During observations on January 29, 2025, at approximately 9:30 AM, it was observed that a device resembling a camera was observed on the bedside dresser of Resident 27. During a staff interview at approximately 9:36 AM, Employee 9 stated that it was a monitor for Resident 27 to monitor Resident 27 at night due to Resident 27 having a history of attempting to get out of bed and falling. At the time of the observation Resident 27 was not in bed, nor in the room. Observation of the nurses' station adjacent to the unit Resident 27 resided, revealed two small monitor screens. Both screens were in direct line of sight from the hallway. During the observation, no staff were sitting at the nurses' station. It was observed that both monitors were on at that time. Review of Resident 27's physician's orders revealed an order dated January 13, 2025, for, Safety measures: encourage grip socks in bed, offer [out of bed] to nurses station in restless, camera monitor at bedside, low BED. Review of Resident 27's comprehensive plan of care revealed that it did not include the use of a video/audio monitoring system. Observation of the second monitor revealed it displayed Resident 16 who was laying in bed, facing the camera. It was also observed that audio from Resident 16's room was audible from the monitor, which also included light indicators of the audio transmission. Review of Resident 16's clinical record, revealed diagnoses that included peripheral vascular disease (disease of the cardiovascular system that results in decreased blood flow to the extremities) and type II diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment). Review of Resident 16's physician orders revealed they did not include an order for the video/audio monitoring device. Review of Resident 16's comprehensive plan of care revealed that the use of a video/audio monitor was not included in the comprehensive plan of care. Review of Resident 65's clinical record on January 30, 2025, revealed diagnoses that included epilepsy (neurological condition characterized by seizures caused by abnormal brain activity) and dementia (irreversible, progressive degenerative brain disease that results in decreased ability to perform activities of daily living and decreased contact with reality). Review of Resident 65's physician orders revealed an order dated November 27, 2024, for Safety measures: redirect/reorient/reassure [as-needed] if resident is seeking to get up to go home, camera monitor, [bilateral] crash mat. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 65's comprehensive plan of care revealed it did not include the use of a video/audio monitor. During a staff interview on January 30, 2025, Nursing Home Administrator (NHA) provided a list that revealed seven total residents had video/audio monitoring. Review of the resident list revealed the start date of the monitors were as follows: Resident 16's monitoring device was started on October 1, 2024. Resident 27's monitoring device was started on January 13, 2025. Resident 65's monitoring device was started on November 27, 2024. During a staff interview on January 30, 2025, at approximately 10:15 AM, NHA characterized the video/audio devices as baby monitors. The NHA stated that the use of the monitors is decided during a residents' care plan meeting and that the monitors should be included in the care plan. The NHA further revealed that the facility did not have a policy or procedure for to the protection of Resident(s) privacy with the use of a video/audio monitor. When asked if the facility obtained consent from the resident/resident representative, or the consent of the resident/resident representative of the roommate, the NHA stated that there was no consent obtained. During the staff interview, the NHA revealed that she was not aware that Resident 16's video/audio monitor was transmitting both video and audio. 28 Pa code 201.18(b)(1)(2)(3)(d) Management 28 Pa code 201.29(a) Resident rights 28 Pa code 211.12(d)(1)(3)(5) Nursing services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48484 Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to maintain a safe, clean, comfortable, and home-like environment for one of 30 resident's reviewed (Resident 106). Findings include: Review of facility policy, titled Resident Rights, not dated, read, in part, The Resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Observation in Resident 106's room on January 27, 2025, at 10:01 AM, revealed her tray table was dirty, and the mat overtop was stained with a red substance. Observation in Resident 106's room on January 28, 2025, at 10:48 AM, revealed her tray table was dirty, and the mat overtop was stained with a red substance, same as the day prior. Observation in Resident 106's room on January 29, 2025, at 10:51 AM, revealed her tray table was dirty, and the mat overtop was stained with a red substance, same as the days prior. During an interview with the Nursing Home Administrator (NHA) on January 29, 2025, at 11:12 AM, the surveyor revealed the concern with the observations of Resident 106's tray table. Follow-up interview with the NHA on January 30, 2025, at 10:11 AM, she revealed house keeping staff does weekly rounds to clean rooms, and it is the responsibility of nursing staff to wipe down tray tables daily and clean them as needed. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(3) Nursing services

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305 Based on clinical record review and staff interview, it was determined that the facility failed to conduct a Significant Change Minimum Data Set (MDS - standardized assessment tool utilized to identify a resident's physical, mental, and psychosocial needs) for one of four residents reviewed for hospice status (Resident 70). Findings include: Review of Centers for Medicare and Medicaid Services' Resident Assessment Instrument Version 3.0 Manual provides instructions for completing the resident Minimum Data Set assessment. The manual revealed instructions that a Significant Change Minimum Data Set is required to be performed when a terminally ill resident enrolls into a hospice program (end of life program). Review of Resident 70's clinical record revealed diagnoses that included vascular dementia (brain damage caused by multiple strokes that causes memory loss in older adults) and hypertension (elevated blood pressure caused by the force of blood against the artery walls being too high). Review of Resident 70's MDS assessments revealed Resident 70 had an annual MDS completed with an assessment reference date of April 4, 2024. Review of Resident 70's clinical record revealed that Resident 70 was admitted to Hospice services on March 29, 2024. Review of Resident 70's MDS assessments revealed the facility did not conduct a Significant Change MDS after Resident 70 was admitted to Hospice. Instead, the facility conducted an Annual MDS assessment that had an assessment reference date of April 4, 2024. During a staff interview on January 29, 2025, at approximately 11:00 AM, the Nursing Home Administrator revealed that the facility should have conducted a Significant Change MDS because of Resident 70 entering Hospice services. A copy of the modified MDS dated [DATE], changed to a significant change in status assessment was provided on January 29, 2025. 28 Pa Code 211.12(d)(1)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48484 Based on facility policy review, observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain grooming for one of 30 residents reviewed (Resident 7). Findings include: Review of facility policy, titled Shaving Residents- Preparation, Completion, last revised May 23, 2017, read, in part, Policy: It is the policy of this facility to prepare for and shave residents as needed. Purpose: To provide a uniform process, through which staff prepare for and shave residents. Document in electronic health record. Review of Resident 7's clinical record revealed diagnoses that included hypertension (high blood pressure), anxiety disorder (a persistent a feeling of worry, nervousness, or unease), and neuromuscular dysfunction of bladder (occurs when the nerves that control the bladder are damaged or not functioning properly). Observation of Resident 7 on January 27, 2025, at 11:57 AM, revealed a quarter inch of facial hair over her upper lip and on her chin. Interview with Resident 7 on January 27, 2025, at 11:57 AM, revealed she had a shower that morning and she prefers assistance with shaving on shower days. Observation of Resident 7 on January 28, 2025, at 10:53 AM, revealed a quarter inch of facial hair over her upper lip and on her chin. Observation of Resident 7 on January 29, 2025, at 10:47 AM, revealed a quarter inch of facial hair over her upper lip and on her chin. Review of Resident 7's care plan revealed a focus area of ADLs (Activities of Daily Living) Functional Status, last edited December 23, 2024, with an intervention for I need staff to follow my care profile for specific ADL information, last edited January 29, 2024. Review of Resident 7's clinical record revealed documentation on January 27, 2025, at 7:14 AM, that she received a shower and required Physical help in part of bathing with 1 person physical assist, and documentation that stated How did the resident maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands, and was documented that Resident 7 required Partial/Moderate Assistance. Email correspondence with the Nursing Home Administrator (NHA) on January 29, 2025, at 2:29 PM, revealed she did not have any information to provide regarding Resident 7's facial hair. During a follow-up interview with the NHA on January 30, 2025, at 10:13 AM, she revealed her expectation that staff should offer shaving with showers and as desired. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 33879 Based on clinical record review, hospital record review, and staff interviews, it was determined that the facility failed to provide care and services that met professional standards for one of 30 residents reviewed (Resident 240). Findings include: Review of Resident 240's clinical record on January 29, 2025, revealed diagnoses that included stage three chronic kidney disease (moderate impairment of the kidneys to filter toxins from the blood) and anxiety disorder (mental health disorder characterized by excessive worry and fear). Review of Resident 240's clinical record revealed that Resident 240 was admitted to the facility from the hospital on January 27, 2025, at 1:40 PM. Review of hospital discharge records for Resident 240 revealed that the discharge information did not include any wounds identified on Resident 240. Review of Resident 240's electronic health record revealed that on January 27, 2025, Employee 15 (Licensed Practical Nurse) completed the admission document titled, Other Ulcers, Wounds and Skin Problems, provided the descriptive categories for staff to check that included Infection of the foot (e.g., cellulitis, purulent drainage); Diabetic foot ulcer(s); Other open lesion(s) on the foot; Open lesions(s) other than ulcers, rashes, cuts (e.g., cancer lesion); Surgical wound(s); Burn(s) (second or third degree); Skin tear(s); Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage); None of the above were present. Review of the aforementioned subsection revealed it was marked as, None of the above were present, by Employee 15. Review of the subsection, titled Referrals revealed it provided areas to identify needed referrals to Wound Team [sic], and Wound Clinic and it was marked No Referrals Necessary. Review of paper document, titled Skin Wound Documentation Form, revealed that on January 27, 2025, Employee 15 documented multiple areas, including: wound 1 - wound at the tip of the left great toe that measured 1 centimeters (cm - metric unit of measure) by 0.5 cm; wound 2 - a wound at the top of the right great toe that measured 0.7 cm by 0.7 cm; wound 3 - a wound to the side of the right fifth digit (toe) that measured 0.5 cm by 0.5 cm; and wound 9 - an area at the right chest that measured 0.1 cm by 0.1 cm with the description of open area. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the document revealed that each line had a space for staff to document a Skin Code for each wound identified. Review of the Skin/Wound Codes section revealed that the codes indicated the type of wound identified, with an option of O = Other specify. Review of the wounds identified, wound 1, 2, 3, and 9, revealed Employee 15 documented O. Review of available clinical record revealed no further information on wound characteristics or type of wound was documented by Employee 15. Review of clinical records for Resident 240 revealed no assessment by a registered nurse of the wounds identified. Review Resident 240's progress notes revealed no documentation to the physician that Resident 240 was admitted with wounds that were not previously identified prior to admission. Review of the physician Admission History and Physical Visit, dated January 28, 2025, completed by Physician 2, revealed the Physical exam subsection Skin, stated, no lesions noted of exposed skin. Review of the physician assessment failed to reveal that the physician was made aware or identified the area identified as wounds by Employee 15 upon Resident 240's admission. The facility wound nurse (Employee 18) did not assess the Resident's foot for wounds until January 29, 2025, and did not a progress note regarding assessing the areas until January 30, 2025, at 8:47 AM. During a staff interview with Employee 18 on January 30, 2025, Employee 18 revealed that the Resident had scabs (hard dark brown tissue composed of dried blood, platelets, and fibrin) on her feet but no wounds. However, subsequent observations of Resident 240's right great toe revealed an area at the right great toe consistent with a wound that was covered with eschar (dark, hard area similar to a scab but is composed of dead tissue, debris and dried blood). Review of the consultant wound progress note dated January 30, 2025, revealed Resident 240 was diagnosed with a full thickness arterial wound of the right great toe which was covered with eschar. As of January 30, 2025, at 1:00 PM, the facility had no further information to provide regarding why an assessment of a previously unidentified wound(s) for Resident 240 was not performed by a Registered Nurse upon admission. 28 Pa code 211.12(d)(1)(3)(5) Nursing services

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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. 33879 Based on clinical record review, observation, and staff interviews, it was determined that the facility failed to ensure residents receive treatment and services consistent with professional standards to promote healing and prevent infection for one of two residents reviewed for pressure ulcers (Resident 37). Findings include: Review of Resident 37's clinical record on January 27, 2025, revealed diagnoses that included stage three pressure ulcer of the sacrum (wound that extends below the tissue of the skin caused by pressure over a bony prominence) and congestive heart failure (decreased ability of the heart to pump blood throughout the body). During wound dressing observations on January 29, 2025, at approximately 10:25 AM, Employee 15 (Licensed Practical Nurse) was observed preparing Resident 37 for the wound dressing change on Resident 37's sacral area. After repositioning Resident 37, Employee 15 observed Resident 37 had a bowel movement. Employee 15 cleaned Resident 37's bowel movement prior to starting the dressing change. During the observation, it was observed that Employee 15's gloves were visibly soiled with feces. After cleaning Resident 37's bowel movement and starting the wound dressing change, Employee 15 did not perform hand hygiene with soap and water. Instead, Employee 15 utilized an alcohol-based hand rub during glove changes between cleaning Resident 37's bowel movement and accessing Resident 37's wound. During the observation, it was observed that the dressing that was present on Resident 37 was not dated. After removing the old dressing and cleansing the wound, Employee 15 was observed retrieving a marker from her pocket with her bare hands. At which time, Employee 15 was observed holding two foam dressings one hand and using the marker to write on the new dressing. Employee 15 was observed returning the marker to her pocket. During a staff interview on January 29, 2025, at approximately 11:00 AM, Employee 15 confirmed that her pocket is not considered a clean area. During a staff interview on January 30, 2025, at approximately 10:15 AM, Nursing Home Administrator along with Employee 5 (Registered Nurse/Quality Assurance) confirmed that Employee 15 should have performed hand hygiene with soap and water between cleaning the bowel movement and starting the dressing change, that Employee 15's pocket was not considered a clean surface, and that facility should be labeling wound dressings when they are applied with date and time, and initials. 28 Pa code 211.12(d)(1)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for 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** 40010 Based on facility policy review, clinical records review, observations, and resident and staff interviews, it was determined that the facility failed to ensure that the resident environment was free of accident hazards for one of 30 Residents reviewed (Resident 26). Findings include: Review of facility policy, Tobacco/smoking- communication, interventions, guidelines, last revised March 2, 2017, revealed that Rest Haven-[NAME] is a smoke and tobacco-free facility/campus. Review of Resident 26's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing inflammation and narrowing of the airways, leading to difficulty breathing) and normal pressure hydrocephalus (a condition where excess cerebrospinal fluid [CSF] accumulates in the brain's ventricles [fluid-filled spaces] without an increase in intracranial pressure). Observation of Resident 26 on January 28, 2025, at 10:04 AM, revealed Resident 26 sitting in her wheelchair in the facility parking lot, next to Employee 9, smoking a cigarette. Interview with Resident 26 on January 29, 2025, at 9:34 AM, revealed that Resident 26 keeps her cigarettes and lighter in her room and that she has nowhere to lock them up, where they cannot be accessed by other residents. Review of Resident 26's medical record on January 28, 2025, failed to reveal any smoking evaluation for Resident safety. Review of Resident 26's care plan failed to reveal a care plan with a focus area related to safety while smoking. Review facility provided email from Resident 26's Representative dated December 11, 2024, at 12:33 PM, revealed that Resident 26 had a desire to smoke cigarettes, and she would leave the facility to do so. Interview of the Nursing Home Administrator on January 28, 2025, at 1:30 PM, revealed that the facility was aware that the Resident was smoking and that they required her to leave the facility grounds to smoke. She also revealed that facility employees are not permitted to take the Resident out to smoke while clocked in to work. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48484 Based on facility policy review, observation, review of select facility documentation, and staff interviews, it was determined that the facility failed to utilize kitchen equipment in accordance with professional standards for food service safety in the main kitchen. Findings include: Review of facility policy, titled Machine Warewashing, last revised December 1, 2007, read, in part, Purpose: To ensure that the dishwashing machine is operating in accordance with facility guidelines, department policy, manufacturers specifications and regulatory guidelines. Policy: The dish washing machine is serviced on a regular basis. Wash and rinse temperatures of the dish machine are monitored during each major use (3 times daily). Acceptable temperature ranges are: wash- minimum 150 degrees. If the machine operating temperatures are lower than the specified minimum temperature staff members will suspend the machine washing and notify the Dietary Supervisor, and/or the Food Service Director, and/or the Assistant Food Service Director and maintenance personnel. The following process will be used to assess machine operation: The holding tank temperature will be confirmed with a pocket thermometer. The booster heater will be checked to confirm that it is switched on. The holding tank may be emptied and reloaded with fresh water. Temperatures will be rechecked. If the temperature of the dish machine falls below 150 degrees, the bleaching system should be hooked up and booster heater turned off to utilize the low heat option. Observation of the January 2025 dish machine temperature log in the main kitchen on January 27, 2025, at 9:43 AM, revealed the wash temperature was below the minimum safe temperature of 150 degrees on January 9-12 during breakfast; January 9-14 during lunch; and January 8, 16, 21 and 22 during dinner. No corrective action was noted. Interview with Employee 2 (Food Service Director) on January 27, 2025, at 9:44 AM, revealed staff had not made her aware of the low temperatures in January 2025. Review of the dish machine temperature logs from May 2024 through January 2025, revealed If minimum temperature is not met- Please contact maintenance. Review of the May 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on May 7-9, 11, 12, 14-17, 20, 23, 25-28, and 30 at breakfast; May 8, 9, 11, 12, 14-17, 20, 23, 25-28, and 30 at lunch; and May 10, 14, 16, 17, 20-24 at dinner. Further review failed to reveal notation of corrective action taken. Review of the June 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on June 5-11, 13, 25, 27, 28, and 30 at breakfast; June 2, 3, 5-11, 13, 14, 17, 18, 22-24, 27, 28, and 30 at lunch; and June 4, 5, 12, 13, 19, and 25 at dinner. Further review failed to reveal notation of corrective action taken. (continued on next page)

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	395058	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rest Haven-York	1050 South George Street York, PA 17403

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the July 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on July 3-11, 15-21, 23, 25, and 29-31 at breakfast; July 2-11, 16-23, 26, 30 and 31 at lunch; and July 3 and 26 at dinner. Further review failed to reveal notation of corrective action taken. Review of the August 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on August 1, 3-5, 7, 8, 12-15, 17, 18, 22-24, 26-29, and 31 at breakfast; August 1, 3-5, 7, 8, 10, 12, 13, 15, 17, 18, 20, 22-24, 26-29 and 31 at lunch; and August 1, 3, 15, and 30 at dinner. Further review failed to reveal notation of corrective action taken. Review of the September 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on September 1, 4, 5, 7, 10-12, 14, 15, 19, 22, 23, 25, 28, and 29 at breakfast; September 1, 4-7, 10-15, 19-23, 25, 28 and 29 at lunch; and September 2, 12, and 21 at dinner. Further review failed to reveal notation of corrective action taken. Review of the October 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on October 1, 8, 11-13, 17, 19-23, 26, 27, and 29-31 at breakfast; and October 8, 10-13, 17, 19-23, 26, 27, 30 and 31 at lunch. Further review failed to reveal notation of corrective action taken. Review of the November 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on November 5-11, 15-24 and 26-30 at breakfast; and November 1, 5-12, 18-24, and 27-30 at lunch. Further review failed to reveal notation of corrective action taken. Review of the December 2024 dish machine temperature log revealed the wash temperature was below the minimum safe temperature of 150 degrees on December 1-13 and 20-25 at breakfast; December 1-9, 11-17, and 21-25 at lunch; and December 1 and 3 at dinner. Further review failed to reveal notation of corrective action taken. Interview with the Nursing Home Administrator on January 29, 2025, at 11:13 AM, revealed she was unable to provide information if the facility process was followed when the dish machine was running below the minimum acceptable wash temperature, and it is the facility's expectation that kitchen equipment is utilized in accordance with professional standards. 28 Pa. Code 201.18(b)(1) Management

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879 Based on observations, facility policy review, and staff interviews, it was determined that the facility failed to ensure staff implemented infection control policies to prevent the spread of infection by doffing PPE (personal protective equipment) prior to exiting the resident room in two of seven resident care areas observed (100 and 700 hall), and failed to properly disinfect resident areas after one of two dressing changes observed (Resident 12). Findings Include: Review of facility policy with the subject of, PRECAUTIONS, CONTACT - Notification, Initiation, Communication, Prevention, Discontinuation, last revised March 30, 2021, revealed the policy's purpose stated, To provide a uniform process through which facility is notified of potentially harmful microorganisms, contact precautions are initiated, risk is communicated, spread of microorganisms is prevented and contact precautions are discontinued. Review of the aforementioned policy's Procedure section revealed it included, 5. Obtain a container for dirty linens and place inside the resident's room .10. The following personal protective equipment will be used when caring for residents with a potentially harmful microorganism: a. Gloves - required when entering a resident's room, when anticipating direct contact with a resident, [the residents] environment or [the residents] equipment that could result in contamination of the hands; remove gloves and wash hands immediately before leaving the room . Review of Resident 24's clinical record revealed diagnoses that included diabetes (a chronic disease that occurs when the body doesn't produce enough insulin or can't use insulin properly) and peripheral vascular disease (a condition that affects the blood vessels outside the heart and brain). Review of Resident 24's current physician orders revealed an order for enhanced barrier precautions related to a wound, with a start date of November 24, 2024, and no end date. Observation of Employees 7 and 8 on January 27, 2025, at 10:11 AM, revealed them wearing protective gowns while providing care to Resident 24, who is on enhanced barrier precautions. After Employees 7 and 8 completed providing the care, they exited Resident 24's room and entered the hallway, still wearing the protective gowns. Employees 7 and 8 then removed their gowns and disposed of them in the garbage can located in the hallway. Interview with the Nursing Home Administrator (NHA) on January 28, 2025, at 1:15 PM, revealed that the garbage cans are located in the hallway because of a lack of space in the resident rooms, and that her expectation is that the employees would have removed their gowns and gloves before exiting the Resident room and put them in a garbage bag; which they could then place into the garbage can that was located in the hallway. Review of facility policy, Precautions, Enhanced Barrier, last revised November 11, 2024, failed to reveal a location that PPE should be removed and disposed of. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 12's clinical record revealed diagnoses that included pressure ulcer (a localized area of skin damage that develops when prolonged pressure is applied to a specific area of the body) and heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively). Observation of a dressing change completed by Employee 6 on January 29, 2025, at 9:31 AM, revealed Employee 6 completed a dressing change on Resident 12's ankle. After completing the dressing change, Employee 6 gathered up the garbage from the supplies used, including the bandage that was removed from Resident 12's ankle and the gauze that was used to clean the pressure ulcer on her ankle, and placed them into a biohazard garbage bag. Employee 6 then sat that garbage bag on Resident 12's bedside table. Employee 6 finished gathering her supplies and exited Resident 12's room and disposed of the garbage in the appropriate receptacle. At no time did Employee 6 cleanse Resident 12's bedside table after sitting the garbage bag filled with biohazard garbage on it. Interview with the NHA on January 29, 2025, at 1:15 PM, revealed that her expectation would be that the Employee would have cleansed the bedside table after it was contaminated. Review of Resident 37's clinical record on January 27, 2025, revealed diagnoses that included stage three pressure ulcer of the sacrum (wound that extends below the tissue of the skin caused by pressure over a bony prominence) and congestive heart failure (decreased ability of the heart to pump blood throughout the body). Further review of Resident 37's clinical record revealed that Resident 37 was on contact precautions due to an infection with a multi-drug resistant organism (MDRO). During wound dressing observations on January 29, 2025, at approximately 10:25 AM, Employee 15 (Licensed Practical Nurse) was observed preparing Resident 37 for the wound dressing change on Resident 37's sacral area. Employee 15 was assisted with repositioning the Resident, including handling Resident 37's foley catheter bag. During the dressing change observation, Employee 15 was observed placing Resident 37's foley catheter bag on the Resident's bed during repositioning. After Resident 37 was repositioned, Employee 19 handled Resident 37's foley catheter bag and hung it on the bed frame. Employee 15 then placed a red biohazard bag onto the Resident's bed in the approximate same location that the foley bag was placed earlier. After the dressing change, Employee 15 and Employee 19 exited the room while wearing gown and gloves (personal protective equipment utilized while providing care to Resident 37). Employee 15 was observed holding the red biohazard bag with her gloved hand. Both Employee 15 and 19 removed the gloves and gowns while in the hallway. Employee 15 was then observed handling the red biohazard bag with her bare hand. Employee 15 was then observed walking through the hall of the [NAME] unit to the nurses' station while holding the red bag. Employee 15 then retrieved a key attached to a piece of metal from the wall at the nurses' station. Employee 15 was then observed opening a utility closet, unlocking a freezer, and placing the red biohazard bag into the freezer, after which Employee 15 exited the room and returned the key to it's hanging apparatus on the wall at the nurses' station. Finally, Employee 15 washed her hands with soap and water at the nurses' station. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a staff interview directly after the observation, Employee 15 was asked if she knew when the key she had utilized was last cleaned. Employee 15 responded that she did not know. When asked if the key is ever cleaned, Employee 15 responded that she did not know. Interview with the NHA on January 29, 2025, at approximately 1:00 PM, the NHA again confirmed that staff should be removing gown and gloves while in the room, placing them in a bag and then exiting the room to dispose of the gown and gloves in the disposal bin outside of the resident room. During a staff interview on January 30, 2025, at approximately 10:15 AM, the NHA agreed that the observation of Employee 15 transporting the red biohazard bag with her bare hand and touching other surfaces during that time was an infection control concern. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services