STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395567	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunmore Health Care Center	1000 Mill Street Dunmore, PA 18512

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and select facility policy and staff interview, it was determined the facility failed to demonstrate it had ascertained if a resident had an advance directive upon admission and whether the resident would like information to formulate an advance directive for two out of 18 sampled residents (Residents 74 and 18). Findings included: A review of a facility entitled Advance Care Planning meeting Protocol last reviewed by the facility on December 2, 2024, indicated that it was the policy of the facility that upon admission to the facility, the appropriate team member would meet with the resident and offer to formulate an advance directive to ensure their preferences (Living Wills, Medical [NAME] of Attorney, etc.) are recorded in their medical record and further used to develop their plan of care. Social Services, along with other team members as needed, will meet with the resident and family members within a reasonable timeframe (3-5 days from admission) to discuss pertinent information regarding the resident's wishes. A review of Pennsylvania Statute Title 20: Chapter 54: Healthcare revealed that an advance health care directive is a health care power of attorney, a living will, or a written combination of a health care power of attorney and a living will. A review of the clinical record revealed that Resident 74 was admitted to the facility on [DATE], with diagnoses that included esophageal cancer (a tumor that occurs in esophagus - tube which connects from throat to the stomach, resulting in difficulty in swallowing, chest pain, cough, sudden weight loss and heartburn), metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body and may be reversible if the preexisting disorders are treated), and protein calorie malnutrition (the state of inadequate intake of food as a source of protein, calories, and other essential nutrients occurring in the absence of significant inflammation, injury, or another condition that elicits a systemic inflammatory response). Review of Resident 74's admission Minimum Data Set (MDS- a federally mandated standardized assessment process completed periodically to plan resident care) dated November 5, 2024, revealed the resident was cognitively intact with a BIMS (brief interview mental screening tool used to screen and identify cognitive impairment) score of 15 (12 to 15 indicates intact cognition). (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 74's clinical record revealed a Pennsylvania Physician Orders for Life-Sustaining Treatment (POLST- The POLST is not intended to replace an advance health care directive document or other medical orders. The POLST process and health care decision-making works best when the person has appointed a health care agent to speak for them when they become unable to speak for themselves. A health care agent can only be appointed through an advance health care directive or a health care power of attorney), but no documented evidence of an Advance Directive or if the facility asked the resident if he would like information to formulate an advance directive. Further review of Resident 74's clinical record failed to reveal documented evidence that facility staff offered the resident the opportunity to formulate an Advanced Directive. Additionally, there was no documented evidence that the facility determined if the resident had or did not have an Advance Directive or Healthcare Power of Attorney. A review of the clinical record revealed Resident 18 was admitted to the facility on [DATE], with diagnoses that included unspecified 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). Review of Resident 18's admission Minimum Data Set (MDS- a federally mandated standardized assessment process completed periodically to plan resident care) dated November 23, 2024, revealed the resident was severely cognitively impaired. Resident 18's clinical record revealed a Pennsylvania Physician Orders for Life-Sustaining Treatment (POLST- The POLST is not intended to replace an advance health care directive document or other medical orders, the POLST indicated the resident was a DNR (do not resituate) but there was no documented evidence of an Advance Directive or evidence that the facility discussed advance directives and offered the opportunity to formulate one with the residents representative. Further review of Resident 18's clinical record failed to reveal documented evidence that facility staff offered the resident the opportunity to formulate an Advanced Directive. Additionally, there was no documented evidence that the facility determined if the resident had or did not have an Advance Directive or Healthcare Power of Attorney. An interview with the social services director (SSD) on December 11, 2024, at 10:30 AM, confirmed there was no documented evidence to indicate the facility had determined if Residents 74 and 18 had or did not have an advance directive upon admission to the facility. The SSD confirmed there was no documented evidence that Resident 72 or Resident 18 were made aware of the right to formulate an advance directive and that information to formulate an advance directive could be requested and provided by the facility. 28 Pa. Code 201.29 (a)(b) Resident rights

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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** 39929 Based on a review of clinical records and facility-initiated transfer notices and a staff interview, it was determined the facility failed to provide written notices of facility-initiated hospital transfers to the resident and their representative for one resident out of the 18 sampled (Resident 2). Findings include: A review of Resident 2's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease. A review of the clinical record revealed that Resident 2 was transferred to the hospital on November 20, 2024, and was readmitted to the facility on [DATE]. A review of the clinical record failed to reveal documented evidence the facility provided the resident and the resident's responsible party (RP) with a written notice of the facility-initiated transfer and reason for the transfer on November 20, 2024. An interview with the Nursing Home Administrator on December 12, 2024, at 9:10am, confirmed the facility had no documented evidence Resident 2's responsible parties were provided with a written notice of the facility initiated transfer that was initiated on November 20, 2024. 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** 39929 Based on a review of clinical records and a staff interview, it was determined that the facility failed to provide written notice of the facility's bed hold policy to a resident and the resident's representative upon the resident's transfer to the hospital for one resident out of the 18 sampled (Resident 2). Findings include: A review of the clinical record revealed that Resident 2 required transfer to the hospital on November 20, 2024, and was readmitted to the facility on [DATE]. There was no documented evidence that the residents and/or their responsible parties or legal representatives were provided written information about the facility's bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) at the time of transfer. During an interview on December 12, 2024, at approximately 9:10 am, the Nursing Home Administrator (NHA) was unable to provide evidence that the facility made Resident 2 and their representative, aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital. 28 Pa Code 201.18 (e)(1) Management 28 Pa Code 201.29 (a) 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** 43944 Based on a review of clinical records and the Resident Assessment Instrument and staff interviews, it was determined the facility failed to ensure the Minimum Data Set Assessments accurately reflected the status of one resident out of 18 sampled (Resident 49). Findings include: A review of the clinical record revealed that Resident 49 was admitted to the facility on [DATE], with diagnoses to have included cardiovascular disease, depression, and diabetes. A review of Resident 49's quarterly review Minimum Data Assessment (MDS-a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 2, 2024, revealed in Section P - P0100 Restraints was coded D Other to indicate the resident had a form of restraints in place. A review of Resident 49's clinical record failed to reveal that the resident had restraints in place. An interview with the Director of Nursing (DON) on December 12, 2024, at 10:00 AM, revealed that Resident 49 did not have physician's orders for restraints or require restraints and confirmed the quarterly MDS November 2, 2024, Section P0100 Restraints was coded in error to indicate the resident had a restraint in place. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c)(d)(1)(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. 39929 Based on observation, review of clinical records, and resident and staff interviews it was determined the facility failed to provide services consistent with professional standards of practice by failing to follow physician orders for bowel protocol for one resident (Resident 59) out of 18 residents reviewed to promote normal bowel activity to the extent practicable. Findings include: According to the American Academy of Family Physicians (The American Academy of Family Physicians is one of the largest medical organizations in the US founded to promote the science and art of family medicine) the primary goal of constipation management should be symptom improvement, and the secondary goal should be the passage of soft, formed stool without straining at least three times per week. A review of the clinical record revealed that Resident 59 had physician orders dated May 1, 2024, for the following bowel regimen: - Milk of Magnesia (MOM) Suspension 400 mg/5ML (Magnesium Hydroxide), Give 30 ml by mouth as needed for constipation if no BM (bowel movement) after the third day. -Bisacodyl suppository; 10 mg; insert 1 suppository rectally as needed for constipation if no BM on the fourth day and no result from MOM. -Enema (Mineral Oil), insert 1 application rectally as needed for constipation if no BM on the fifth day and no result from the suppository notify md if no bowel movement. Review of Resident 59's bowel tracking for November 2024, revealed that Resident 59 did not have a bowel movement on November 19, 20, 21, 22, and 23, 2024. Review of Resident's Medication Administration Record (MAR) for November 2024, revealed no documented evidence that nursing administered the prescribed bowel protocol during the time period without a bowel movement to promote bowel activity. There was no documented evidence the staff had notified the physician the resident went five consecutive days, November 19, 20, 21, 22, and 23, 2024, without a bowel movement. During an interview with the Director of Nursing (DON) on December 12, 2024, at 9:20 AM, the DON was unable to provide evidence the physician ordered bowel protocol was followed for Resident 59 during the period without bowel activity stated above, nor evidence of timely physician notification. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 211.5(f) Medical records

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records, select facility policy, and resident and staff interviews, it was determined the facility failed to ensure residents receive appropriate services and assistance to maintain or improve mobility with the maximum practicable independence for one resident out of 18 sampled (Resident 6). Findings include: A review of policy entitled Restorative Nursing Referral and Process Policy last reviewed by the facility on December 4, 2024, revealed it is the policy of the facility that Residents who could benefit from the nursing restorative program can be identified at the following times: -on admission -when other assessments are required, such as an MDS assessment -from the 24 hour report and the change of shift report -at morning stand up meeting -at care plan meeting and other resident-focused meetings -at risk management meetings such as behavior management, nutrition at risk -during restorative weekly meetings. The procedure to include, a referral from the therapy department, goals can be written in the initial evaluation for resident participation in the restorative program. It was indicated the restorative program is a nursing program and is at the discretion of the nursing restorative coordinator. Further a care plan will be developed for a restorative program. Clinical record review revealed that Resident 6 was admitted to the facility on [DATE], with diagnoses which included diabetes and muscle weakness. A quarterly MDS (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 20, 2024, revealed the resident to be cognitively intact with a BIMS score of 15 (BIMS (Brief Interview for Mental Status) is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility. A score of 13-15 indicates cognitively intact) and required staff assistance for activities of daily living. A review of a physical therapy discharge summary dated May 23, 2024, revealed a recommendation of discharged from therapy services and start restorative nursing program (RNP) for range of motion of bilateral lower extremities. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review a care plan for ADL functional status/rehabilitation dated May 22, 2024, restorative nursing interventions to include active range of motion to left lower extremities for 30 repetitions and passive range of motion to right lower extremity for 30 repetitions. A review of nursing staff documentation dated November 1, 2024, through November 30, 2024, revealed that staff completed RNP exercises for Resident 6 daily for between 2 minutes and 30 minutes daily. There were no nursing evaluations of the RNP program to include resident progress, the continuation of the services or the need to revise the program from the inception of the program May 22, 2024, through the end of the survey December 12, 2024. During an interview on December 11, 2024, at approximately 11:00 AM, the Assistant Director of Nursing confirmed residents RNP programs should be evaluated monthly and documented in the medical record. She stated that she had not reviewed any of the programs since taking over the program in May 2024. During an interview December 12, 2024 at 10:00 AM, the Nursing Home Administrator confirmed it is the facility's responsibility and policy to ensure residents receive appropriate services and assistance to maintain or improve mobility with the maximum practicable independence. 28 Pa. Code: 211.12(d)(3)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43944 Based on a review of select facility policy, clinical records, and staff interviews it was determined that the facility failed to develop and implement individualized measures for the toileting needs of two residents out of 18 sampled residents for bowel and bladder management (Residents 27 and 74). Findings included: A facility policy entitled Continence Management Programs last reviewed by the facility December 2, 2024, indicated that the facility will design a plan to manage incontinence that is developed according to the resident's needs and capabilities. Upon admission, the admitting Nurse will complete a head-to-toe assessment which includes interview of resident and review of underlying conditions such as potential or actual diagnoses that may affect the ability to participate in a continence management program. The nursing staff will identify each resident who is incontinent, assess, and plan appropriate treatment and services to achieve or maintain as much normal urinary and/or bowel function as possible. Additionally, the policy indicted that a Continence Evaluation will be conducted to determine if a 72-hour Bowel and Bladder Tracking is indicated. If tracking is indicated, the licensed Nurse will instruct the nursing assistants (NA) to fill out the form. When a new pattern has been identified, a new Continence Evaluation will be completed and the licensed nurse will develop a toileting plan, determining the approaches needed to achieve the goal(s), establish the type of staff intervention needed to meet each resident's goal(s), select equipment and aids needed to be successful and note the interventions, and review the plan as needed to identify any necessary modifications. A review of Resident 27's clinical record revealed that the resident was most recently readmitted to the facility on [DATE], with diagnoses that included sepsis (an infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever), COPD (chronic obstructive pulmonary disease an ongoing lung condition caused by damage to the lungs and the damage results in swelling and irritation), and morbid obesity (is a complex chronic condition that can lead to several serious health issues). A review of the resident's Admission/Readmission Observation completed by Employee 1 RN (registered nurse) dated September 27, 2024, at 4:49 PM, revealed the resident always was incontinent of urine and always incontinent of bowel and required adult incontinence briefs to manage incontinence. Additionally, at the time of the readmission observation assessment, Employee 1 initiated a Continence and Retraining/Scheduled Toileting and Decision/Determination Observation form that indicated bladder and bowel were to be assessed due to readmission. Resident 27's had a history of UTI's (urinary tract infections), functionally was unable to walk to the bathroom which required the use of a wheelchair for locomotion, and usually aware of her toileting needs. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, Resident 27's Continence and Retraining/Scheduled Toileting and Decision/Determination Observation form failed to reveal that staff completed a 72-hour bladder and bowel tracking form to assess the resident's continence to potentially implement a scheduled toileting program, as practicable, or develop individualized incontinence management schedule. A review of Resident 27's comprehensive person-centered plan of care revealed the facility failed to indicate the resident's bladder and bowel continence status or her individualized toileting/incontinence management program to ensure the resident's highest practicable level of independence and dignity. During an interview with the Assistant Director of Nursing (ADON) on December 12, 2024, at 9:17 AM, revealed that the facility could not provide documented evidence that Resident 27's bladder and bowel continence/incontinence was assessed, and that a 72-hour bladder and bowel tracker was completed as per facility policy. A review of the clinical record revealed that Resident 74 was admitted to the facility on [DATE], with diagnoses that included esophageal cancer (a tumor that occurs in the tube which connects from throat to the stomach resulting in difficulty in swallowing, chest pain, cough, sudden weight loss and heartburn), metabolic encephalopathy (is a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), and protein calorie malnutrition (is the state of inadequate intake of food), A review of the resident's Admission/Readmission Observation completed by the ADON dated October 31, 2024, at 5:05 PM, revealed that the resident was able to stand and pivot from wheelchair with assistance, was alert and oriented and understands clear-comprehension, and always continent of urine with use of urinal. The resident's bowel continence section was not completed. A review of Resident 74's admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 5, 2024, revealed that the resident was cognitively intact with a BIMS (brief interview mental screening tool used to screen and identify cognitive impairment) score of 15 (12 to 15 indicates cognitive intact), required substantial/extensive assistance from staff for transfers, and toileting, and toileting hygiene. Additionally, the admission MDS was coded to indicate that a trial urinary and trial bowel toileting program was not attempted and was occasionally incontinent of urine, frequently incontinent of bowel, and was not on a bladder or bowel toileting program. Resident 74's clinical record failed to reveal any documented evidence that continence/incontinence status was assessed to develop and implement an individualized toileting or incontinence management program to ensure the resident's highest practicable level of independence and dignity. An interview with the Assistant Director of Nursing (ADON), on December 12, 2024, at 9:30 AM, revealed the facility could not provide documented evidence that upon admission Resident 74's bladder and bowel continence/incontinence was assessed, and that a 72-hour bladder and bowel tracker was completed as per facility policy, and plan of care was fully developed to reflect the resident's toileting needs. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At the time of the interview with the ADON, it was confirmed that upon admission the facility failed to assess Resident 27 and Resident 74's bladder and bowel continence/incontinence and failed to complete a 72-hour bladder and bowel tracker as per facility policy, and that the facility failed to fully develop a plan of care to reflect the resident's toileting needs to ensure the resident's highest practicable level of independence and dignity. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(a)(d) Resident care policies

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and staff interview, it was determined the facility failed to develop and implement an individualized person-centered plan to render trauma informed care to a resident with a diagnosis of Post-Traumatic Stress Disorder for one out of 18 residents reviewed (Resident 78). Findings include: A review of Resident 78's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included Post Traumatic Stress Disorder (PTSD a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event). The resident's current care plan, in effect at the time of review on December 11, 2024, did not identify the resident's PTSD symptoms or triggers related to this diagnosis and resident specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization. The facility failed to develop and implement an individualized person-centered plan to address, this resident's diagnosis of PTSD according to standards of practice to promote the resident's emotional well-being and safety. Interview with the Director of Social Services on December 11, 2024, at approximately 11:00 a.m., confirmed she was unaware of the resident's PTSD diagnosis and there had not been a care plan in place to address the resident's diagnoses of PTSD. Interview with the Nursing Home Administrator on December 11, 2024, at 1:00 p.m., confirmed the facility was unable to demonstrate the facility provided culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. 28 Pa Code 211.12 (d)(3)(5) Nursing services.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and staff interview, it was determined 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 18 residents (Resident 18 and 19). Findings include: A review of Resident 18's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included 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). A review of Resident 18's Admission Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 23, 2024, revealed the resident was severely cognitively impaired. A review of the resident's current care plan, initially dated November 21, 2024, revealed no documented evidence the facility had developed an individualized person-centered plan for the resident's dementia care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety and using individualized, non-pharmacological approaches to care, including purposeful and meaningful activities that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being. The facility failed to develop and implement an individualized person-centered plan to address, modify and manage this resident's dementia-related behaviors. The resident's care plan for dementia failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage, modify or decrease the resident's dementia-related behavioral symptoms. A review of Resident 19's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included acute dementia. A review of Resident 19's Quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 21, 2024, revealed the resident was severely cognitively impaired. A review of the resident's care plan initiated July 18, 2022 for cognitive deficit indicated the resident had a diagnosis of Dementia with Lewy Bodies (Lewy body dementia causes a decline in mental abilities that gradually gets worse over time. People with Lewy body dementia might see things that aren't there. This is known as visual hallucinations. They also may have changes in alertness and attention). (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's current care plan, initially dated April 15, 2024, in effect at the time of the survey ending December 12, 2024, revealed no documented evidence the facility had developed an individualized person-centered plan for the resident's dementia care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety and using individualized, non-pharmacological approaches to care, including purposeful and meaningful activities that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being. The facility failed to develop and implement an individualized person-centered plan to address, modify and manage this resident's dementia-related behaviors. The resident's care plan for dementia failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage, modify or decrease the resident's dementia-related behavioral symptoms. Interview with Nursing Home Administrator on December 12, 2024, at approximately 10:00 AM, confirmed the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to address the resident's dementia care. 28 Pa Code 211.12 (d)(3)(5) Nursing services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review and staff interviews, it was determined the facility failed to ensure the presence of physician documentation of the clinical rationale for the continued administration of an antidepressant medication for one resident out of five sampled residents for unnecessary medication use. (Resident 19). Findings included: A review of Resident 19's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included acute dementia (a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life). A review of Resident 19's Quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 21, 2024, revealed the resident was severely cognitively impaired. A review of current Physicians orders dated April 4, 2024, revealed orders for Mirtazapine 15 mg (an antidepressant medication) by mouth at bedtime for depression, Trazadone 200 mg (an antidepressant medication) by mouth at bedtime for depression, and Sertraline 50 mg (an antidepressant medication) by mouth at bedtime for depression. A review of a pharmacy consultation report dated October 14, 2024 completed by the consultant facility pharmacist recommended a gradual dose reduction (GDR) of the residents Mirtazapine 7.5 mg antidepressant medication. The GDR request was declined by the RN nurse practitioner on October 17, 2024. The documented reasoning was resident recently hospitalized secondary to behavior against staff. A GDR is contraindicated. A review of a pharmacy consultation report dated November 15, 2024 completed by the consultant facility pharmacist recommended a gradual dose reduction (GDR) of the residents Trazadone antidepressant medication. The GDR request was declined by the physician assistant on November 19, 2024. The documented reasoning stated Residents psych medications are managed by the consultant psychiatrist. Please defer to this physician for medication management. Further review of the pharmacy consultant report failed to include a resident specific rationale to justify the continued use of the multiple antidepressants in use for this resident. In addition, there was no documented evidence at the time of the survey to justify the concurrent use of multiple antidepressant medications for this resident. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing (DON), on December 11, 2024, at approximately 1:00 PM, confirmed the facility failed to ensure that Resident 19's attending physician provided clinical justification/rationale for the continued administration of antidepressant medication and the concurrent use of multiple antidepressant medications. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (c) Nursing services. 28 Pa. Code 211.2 (d)(3) Medical Director

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review and staff interview, it was determined the facility failed to maintain accurate clinical records for one of 18 residents sampled (Resident 19). Findings include: A review of Resident 19's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included acute dementia (a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life). A review of a care plan initiated July 18, 2022, for cognitive deficit revealed the resident has a diagnosis of Dementia with Lewy Bodies (Lewy body dementia causes a decline in mental abilities that gradually gets worse over time. People with Lewy body dementia might see things that aren't there. This is known as visual hallucinations. They also may have changes in alertness and attention). The facility was noted to have changed clinical record systems on April 8, 2024. The above noted care plan was not completely transferred, to include the dementia care plan for Resident 19, from the initial electronic medical record system to the system currently in use at the facility at the time of the survey ending December 12, 2024. During an interview conducted on December 11, 2024, 11:00 AM, the Director of Nursing (DON) confirmed that Resident 19's current care plan was incomplete. She stated that the facility changed electronic records systems on April 8, 2024, and all the resident medical information was not transferred from the prior electronic clinical records to the current system. The DON stated she did not know how many of the current residents at the time of the survey had complete medical records. 28 Pa Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review clinical records and facility provided documents it was determined the facility failed to develop and implement a quality assurance plan, which was able to identify, and correct ongoing quality deficiencies related to complete and accurate medical records. Findings include: A review of a facility policy for Quality Assurance and Performance Improvement (QAPI) program reviewed December 4, 2024, revealed the purpose of QAPI in the facility is to take a proactive approach to continually improving delivery of care and services and to engage residents, caregivers, and other clinical/operational partners in maximizing quality of life and quality of care. The facility will conduct performance improvement projects to examine and improve care and services which have been identified as opportunities for improvement. A review of Resident 19's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included acute dementia (a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life). A review of a care plan initiated July 18, 2022 for cognitive deficit indicated the resident has a diagnosis of Dementia with Lewy Bodies (Lewy body dementia causes a decline in mental abilities that gradually gets worse over time. People with Lewy body dementia might see things that aren't there. This is known as visual hallucinations. They also may have changes in alertness and attention). The facility was noted to have changed clinical record systems on April 8, 2024. The above noted care plan was not completely transferred, to include the dementia care plan for Resident 19, from the initial electronic medical record system to the system currently in use at the facility at the time of the survey ending December 12, 2024. During an interview conducted on December 11, 2024, 11:00 AM, the Director of Nursing (DON) confirmed that Resident 19's current care plan was incomplete. She stated that the facility changed electronic records systems on April 8, 2024 and all the resident medical information was not transferred from the prior electronic clinical records to the current system. The DON stated she did not know how many of the current residents at the time of the survey had complete medical records. During an interview December 12, 2024, the DON and NHA confirmed the ongoing issue regarding the transfer of medical records into the current electronic medical record was not part of the ongoing quality assurance program at the facility. The facility's quality assurance monitoring plans designed to ensure solutions were sustained, failed to identify the continuing deficient practice with these quality requirements and prevent deficient practice. Refer F744, F842 (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 201.18(e)(1) Management

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observations, review of the facility's infection control tracking logs, the infection control and prevention policy, and staff interviews it was determined the facility failed to develop and implement a comprehensive infection control program to prevent the spread of infectious diseases including scabies for two of 18 residents reviewed (Resident 56 and Resident CR1). Findings include: A review of the current facility policy for Infection Prevention and Control, last reviewed December 4, 2024, revealed it is the policy of the facility to maintain an organized, effective facility-wide program designed to systematically prevent, identify, control and reduce the risk of acquiring and transmitting infections among employees, volunteers, visitors and contract healthcare workers, to conduct surveillance of communicable disease and infectious outbreaks and to monitor employee health. A review of a facility policy entitled Scabies Management reviewed December 4, 2024, revealed, the purpose of the policy is to treat residents infected with and sensitized to scabies and to prevent the spread of scabies to other residents and staff. Affected residents should remain in contact precautions until 24 hours after treatment. Exposed staff members should report any rashes developing on their bodies to the Infection Preventionist or DON (Director of Nursing). A resident sharing a room with someone infected with scabies will be monitored for scabies. If symptoms are not present, daily assessments will occur until the case is resolved. Clinical record review revealed that Resident 56 was admitted to the facility on [DATE], with diagnoses to include heart failure, hypertension (high blood pressure), and anxiety. A quarterly MDS assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 2, 2024, revealed the resident to be moderately cognitively impaired with a BIMS (Brief Interview for Mental Status, a short cognitive screening tool used to assess a person's cognitive functioning) score of 12 (a score of 8 to 12 suggests moderate cognitive impairment) and required staff assistance for activities of daily living. A review of a care plan initiated October 29, 2024 for skin integrity revealed the resident had a rash related to scabies with interventions to include, conduct a systematic skin inspection per facility policy, dermatology consult as needed, discourage resident from scratching area to reduce tissue damage, encourage resident to request medication before symptoms become unbearable, record the location, size (length, width, and depth), color, distribution, contour, consistency of rash(s) per facility policy, and monitor, document, and report to the provider any changes in color, temperature, sensation, pain or presence of drainage and/ or odor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of nursing notes dated September 19, 2024, at 7:50 P.M. revealed the resident's daughter reported Resident 56 had a small rash on her upper right arm, and a small red area was noted. The Resident was noted to be scratching at the area. The rash was cleansed with soap and water. A note was left for the physician to examine the resident. There was no documented nursing skin assessment completed at that time. A review of nursing progress note dated September 20, 2024, at 4:56 P.M. revealed the nurse practitioner was in to see the resident and address the family concerns of the itchy rash. A new order was noted for Hydrocortisone cream 1% (steroid cream) to the rash twice a day until resolved and then reassess. A review of a nursing progress note dated September 27, 2024, at 12:51 P.M. revealed the physician was in to see and examine the resident. The resident complained to the physician about an itchy rash to her right arm. New orders were noted to start a Medrol dose pack (oral steroids) and Clobetasol 0.05% cream (a medication used to treat skin conditions) twice a day for 5 days. A review of a skin assessment dated [DATE] revealed, an existing skin issue noted, scab on lower mid back, with no redness. There was no documentation of a rash on the assessment form at that time. A review of a nursing progress note dated October 6, 2024, at 8:51 A.M. revealed the physician was in to see the resident and a new order was noted to start Claritin (oral allergy medication)10 mg by mouth, daily for itch and Betamethasone (topical steroid cream)0.05 topical ointment apply topically to affected areas twice daily. A review of a skin assessment dated [DATE], revealed, an existing skin issue noted. Scratches on lower mid back/ sacrum with no redness or drainage. There was no documentation of a rash on the assessment form at that time. A review of a nursing progress note dated October 16, 2024, at 2:17 P.M. indicated the nurse practitioner saw the resident and discontinued the Claritin and wrote a new order to start Allegra (an oral allergy medication) 180 mg PO (by mouth) daily. A review of a skin assessment dated [DATE] revealed, an existing skin issue noted, dermatitis throughout the resident's body with mid back and sacrum scratches. A review of a skin assessment dated [DATE] revealed, an existing skin issue noted, scratches on the lower mid back and sacrum. No redness or drainage. Small red itchy bumps noted over te resident's entire body. A review of a psychiatry note dated October 28, 2024, 8:24 A.M. by the contracted nurse practitioner stated the resident was seen for a follow up psychiatry visit. The resident stated that her mood is frustrated. The resident spoke in depth regarding her rash and management by her attending physician and lack of sleep. The resident reported anxiety related to her current situation. A nursing note dated October 28, 2024, at 11:48 A.M. revealed, a call was placed to dermatology and an appointment was scheduled for October 29, 2024 at 9:00 A.M. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note dated October 29, 2024, at 10:34 A.M. revealed the resident returned from the dermatology appointment with diagnosis of scabies. A new order was noted to discontinue the Betamethasone (steroid cream) cream and to start Permethrin (anti-scabies treatment) cream apply topically from head to toe when sent from pharmacy, wash off in shower 12 hours post application, maintain contact precautions. Further recommendations included, clothing and bedding should be washed in hot water and any roommate should be treated for possible scabies. Clinical record review revealed that Resident CR1 was admitted to the facility on [DATE], with diagnosis to include after care for a fracture (broken bone) and non-Hodgkin lymphoma (cancer). Resident CR1 and Resident 56 were roommates since Resident CR1's admission to the facility. There was no evidence that after the October 29, 2024, dermatology consultation that Resident CR1 or her responsible party were notified of the diagnosis of scabies and offered treatment as recommended by the dermatology office. A review of nursing documentation dated November 4, 2024 at 11:28 A.M. revealed nursing assessed the resident's skin fully. The resident had small areas where a rash remained. Multiple self-inflicted scratch marks were noted to bottom and top of the arms where there was no rash. The resident still complained of itching. A nurses note dated November 4, 2024 at 4:03 P.M. revealed the physician was called regarding the resident's itching and a new order was noted for Benadryl (an allergy medication) 25mg by mouth every 6 hours as needed for 1 week. A nurses note dated November 4, 2024, at 9:28 P.M. revealed the resident was upset rolling up and down halls and day room cursing at staff about medicines, other residents, her medical records, and food. The resident was unwilling/unable to articulate what was bothering her. Staff asked the resident to please refrain from bad language in public areas. The resident was offered Benadryl for itching, snacks, and drinks. Further the resident indicated she wants a lawyer to make her itching stop. A review of a skin assessment dated [DATE], revealed, an existing skin issue noted, scratches on lower mid back, pimple-like area to right scapula, a rash to right mid back and flank area, and a rash to the right breast and under the right breast. There were no measurements for the noted areas or any additional description of the areas. A nurses note dated November 5, 2024, at 1:28 P.M. indicated dermatology was called regarding the resident's continued complaints of itching, informed of new areas of concern. A new order was noted to start Betamethasone (steroid cream) ointment twice a day. A nursing progress note dated November 5, 2024, at 10:35 P.M. revealed the second dose of permethrin cream was applied and was scheduled to be washed off in the morning. A nurses note dated November 12, 2024, at 1:43 P.M. revealed, the resident was assessed with nursing and physician assistant. A new order noted for Caladryl (anti itch lotion) three times a day and make a follow up appointment with dermatology. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurses note dated November 13, 2024, at 2:26 P.M. revealed the resident returned from the dermatology appointment with new orders for Ivermectin (an oral anti scabies medication) 3 mg, take 4 tablets by mouth on day 1 and repeat 14 days later. A review of a dermatology consultation report dated November 13, 2024, revealed the resident was seen for a follow up visit for scabies. The areas affected were noted as the arms, abdomen, back, buttocks, breast, chest, and legs. The areas were noted as worsened. The physician's findings included small papules and burrows with scales, excoriations, and crust located on the arms, breasts, abdomen, back and buttocks. Another two applications of the Permethrin cream was ordered at that time. There was no evidence at the time of the survey that comprehensive and accurate skin assessments were completed for Resident 56 with symptoms displayed since September 19, 2024 to the survey ending December 12, 2024. An interview with the ADON on November 11, 2024, at approximately 1:00 PM verified the facility failed to implement proper infection control practices, including the facility's established policy and procedures for skin assessments to prevent and mitigate further spread of scabies. 28 Pa Code 211.12 (d)(1)(2)(3)(5) Nursing Services 28 Pa. Code 201.18 (b)(1)(e)(1) Management