STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395654	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bonham Nursing and Rehabilitation Center	477 Bonnieville Road Stillwater, PA 17878

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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 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** 48276 Based on a review of clinical records and staff interviews, it was determined 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 13 sampled (Resident 30). Findings include: A review of the clinical record revealed that Resident 30 was required to be transferred to the hospital on March 11, 2024, and was readmitted to the facility on [DATE]. A clinical record review revealed no documentation that Resident 30 or Resident 30's representative was made aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital. During an interview on August 1, 2024, at approximately 10:30 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were unable to provide evidence that the facility made Resident 30 or the resident's 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 (b) Resident rights

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on clinical record review and staff interview it was determined that the facility failed to develop a comprehensive person-centered plan of care to meet the individualized needs of two residents out of 13 sampled (Residents 3 and 17). Findings include: Review of Resident 17's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to included sick sinus syndrome (heart rhythm disorder which affects the heart's natural pacemaker which controls the heartbeat) and the presence of a pacemaker (small battery-powered device that prevents the heart from beating too slowly, surgically placed under the skin near the collar bone). A review of the resident's current comprehensive care plan, conducted during the survey ending [DATE], failed to include that the resident had a cardiac diagnosis and pacemaker. The care plan did not include how the facility would monitor or the pacemaker or evaluate the resident for symptoms related to the pacemaker not properly functioning. Interview with the director of nursing on [DATE], at 11:30 AM confirmed that the facility failed to address the care and management of Resident 17's cardiac diagnosis and pacemaker on the resident's person-centered plan of care. A clinical record review revealed Resident 3 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and expired at the facility on [DATE]. A review of a significant change in status Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated [DATE], revealed that Resident 3 is severely cognitively impaired with a BIMS score of 07 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of ,d+[DATE] indicates severe cognitive impairment). A care plan indicated Resident 3 has impaired activities of daily life functional ability related to Alzheimer's disease initiated on [DATE]. Interventions in place include having one staff member assist with personal hygiene. A clinical record review revealed a progress note dated [DATE], at 10:32 AM, indicating Resident 3 has full upper dentures. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A documentation survey report revealed Resident 3 was dependent on staff for care or required extensive assistance with personal hygiene, including brushing teeth, on 46 occurrences from [DATE], through [DATE]. A progress note dated [DATE], at 6:17 AM revealed that the resident's dentures were sent to the funeral home. A review of Resident 3's plan of care revealed no identification that Resident 3 utilized dentures, required denture care, or the resident needs and/or preferences regarding dentures. The clinical record had no documented evidence that denture care was consistently being carried out for Resident 3. During an interview on [DATE], at 10:40 AM Employee 7, Nurse Aide (NA), indicated that resident denture care is included in each resident's Kardex (a tool utilized to convey important resident plan of care information). Employee 7, NA, was unable to determine if Resident 3 required denture care. She explained that she remembers assisting her with her hearing aids but does not recall assisting her with denture care. During an interview on [DATE], at 10:45 AM, Employee 8, NA, indicated that staff know when denture care is required by reviewing each resident's Kardex. Employee 7, NA, was unable to find any denture care identified in Resident 3's plan of care. During an interview on [DATE], at approximately 11:00 AM, the Director of Nursing (DON) confirmed that the facility failed to develop a plan of care to ensure Resident 3 received assistance with her oral hygiene related to her denture care. The DON confirmed that the facility failed to develop a plan of care that included and identified Resident 3's denture care. The DON confirmed the facility had no documented evidence Resident 3's dentures were being cleaned or hygienically maintained. Refer F684 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(3)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records and staff interview it was revealed that the facility failed to provide person-centered care to ensure coordination of care with the physician for a pacemaker for one of 13 residents sampled (Resident 17). Findings include: Review of Resident 17's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to included sick sinus syndrome (heart rhythm disorder which affects the heart's natural pacemaker which controls the heartbeat) and the presence of a pacemaker (small battery-powered device that prevents the heart from beating too slowly, surgically placed under the skin near the collar bone). Further review of the clinical record revealed no documented evidence of current physician orders to ensure the care, monitoring, and battery checks required for proper functioning of the pacemaker. An interview with the director of nursing (DON) on August 1, 2024, at 12:00 PM failed to provide documented evidence of person-centered care and physician orders to ensure appropriate care, monitoring, and battery checks related to Resident 17's pacemaker. Refer F656 28 Pa. Code 211.5 (f) Medical Records 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on observation, review of clinical records, select facility incident reports, and resident and staff interviews it was determined that the facility failed to timely and effectively monitor a resident's use of a therapeutic device to preserve skin integrity and prevent pressure sore development, which resulted in the development of an avoidable pressure sore by one resident out of 13 reviewed (Resident 2). Findings: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i. e. support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. Clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses which included diabetes, right impacted distal femur (thighbone) periprosthetic fracture (fracture around a total joint prosthesis) with effusion (abnormal collection of fluids in hollow spaces or tissues of the body), fracture of left distal femoral (area of the leg above the knee joint) screw of ORIF (open reduction and internal fixation) with effusion, and left knee laceration. An admission Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated July 16, 2024, revealed that the resident was cognitively intact with a BIMS (brief interview for mental status) score of 14 (a score of 13-15 indicates cognitively intact, had impairment on both lower extremities with functional limitation in range of motion, was dependent on staff for lower body dressing, and ambulation was not attempted due to medical condition or safety concerns. Review of an admission summary nurses note dated July 9, 2024, indicated that the resident arrived to the facility at 11:25 AM and was transferred into bed with the assistance of four staff. The resident's left lower extremity with immobilizer (a brace which limits knee and leg movement used after an injury or surgery to help knee, muscles, or tendons rest) and surgical dressing in place. Review of admission physician orders dated July 9, 2024, noted an order for immobilizer at all times skin checks every two hours. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's baseline care plan dated July 9, 2024, indicated the resident has impaired immobility related to fracture of the right distal femur and left distal femoral screw of ORIF with a goal to be free from side effects of immobility. Interventions included to utilize pressure relieving devices as ordered. Further review of the baseline care plan revealed no indication that the resident had a left leg immobilizer and/or the care/every two hour skin checks required to ensure effective pressure relief and pressure ulcer prevention related to the use of the leg immobilizer. A review of a Braden Scale (a tool used to determine/predict pressure sore development) dated July 9, 2024, revealed that the resident scored a 13, indicating the resident was at moderate risk for pressure ulcer development. A nurses note dated July 20, 2024, at 1:52 PM noted that an open blister/suspected DTI (deep tissue injury) to the left outer ankle, most likely caused by immobilizer ordered at all times to left lower extremity. Physician aware. New order for Hydrogel (wound treatment) to left lateral ankle topically once daily for open blister/suspected DTI. Cleanse with normal saline solution, apply Hydrogel, cover with bordered dressing. Resident representative aware. An incident report dated July 20, 2024, revealed that a 2.5 cm by 1.1 cm red/purple open blister suspected DTI was noted on the left lateral ankle. The cause was noted to be immobilizer at all times. The resident's statement noted that the cause was unknown. Interventions in place noted the immobilizer was padded and every two-hour skin checks. The new implemented intervention noted Hydrogel as ordered. Extra padding added to immobilizer. Review of Resident 2's July Treatment Administration Record (TAR) from July 9 through July 19, 2024, revealed no indication that skin checks were completed every two hours related to the use of the immobilizer as per physician order. Observation of Resident 2's left left lateral ankle on August 1, 2024, at 9:40 AM and in the presence of Employee 1 (LPN), revealed an intact, slightly reddened, approximate 2.5 cm by 1 cm oval shaped area to the resident's left lateral ankle. During the observation the resident displayed and vocalized no pain and or discomfort. Resident 2 stated during the observation that she was not positive what caused the area but felt it was probably from the leg immobilizer and that she was glad that she no longer had to wear the immobilizer. Further review of the clinical record revealed a physician order dated July 29, 2024, to discontinue the left leg immobilizer. The facility was unable to provide documented evidence that staff had timely and consistently conducted skin integrity checks under the immobilizer prior to the development of the DTI pressure ulcer. During an interview with the Director of Nursing (DON) on August 1, 2024, at approximately 9:00 AM, the DON confirmed that the facility was unable to demonstrate that staff had timely implemented consistent skin integrity checks to prevent the pressure ulcer to the resident's left lateral ankle. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, facility investigations, and select facility policy, and staff interview it was determined that the facility failed to timely implement effective safety interventions, including necessary staff supervision, at the level and frequency required, for a resident with known unsafe behaviors to prevent falls, including a fall with head injury (hematoma) for one resident out of the 13 sampled (Resident 9) and fall with major injury (acute subdural hematoma) for one of the four closed records reviewed (Resident 195). Findings include: A review of facility policy titled Falls Prevention Program, indicated as last reviewed on [DATE], revealed that it is the facility's policy that all appropriate interventions will be implemented specific for each resident's needs to minimize falls and injury and provide safety. The policy also indicated that residents will be provided a safe environment where fall prevention interventions will be implemented to prevent falls or injuries. Falls are reviewed at daily interdisciplinary team meetings to implement, and review fall prevention interventions. Hospital documentation dated [DATE], prior to the resident's admission to the facility on [DATE], revealed that Resident 195 was admitted to the hospital on [DATE], with frequent falls from home. A computed tomography (CT) brain scan completed at the hospital revealed no acute intracranial pathology (no new disease within the skull) and postoperative changes without new, residual, or recurrent subdural hematoma (bleeding that occurs between the brain and its outer covering or the dura due to a head injury). The resident's primary diagnosis at the time of discharge from the hospital was recurrent falls with decreased strength and balance. The hospital's recommendations to the next provider indicated that Resident 195 should continue with physical therapy and occupational therapy and should have 100% supervision given fall risks. A clinical record review revealed that Resident 195 was admitted to the facility on [DATE], with diagnoses that included a history of falling, difficulty walking, and dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A progress note dated [DATE], at 12:52 PM indicated that Resident 195 arrived at the facility and was oriented to her room, call bell, and roommate. The entry indicated that the resident is alert only to herself, {not place or time} and that the resident is able to make needs known. A fall risk assessment dated [DATE], at 1:00 PM revealed that Resident 195 is a high risk for falls with a score of 90 (a score of 45 or higher indicates a high risk for falling). An admission BIMS (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information) assessment, dated [DATE], at 4:16 PM, revealed that Resident 195 was moderately impaired with a score of 9 (a score of ,d+[DATE] indicates moderate cognitive impairment). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A skilled charting assessment dated [DATE], at 4:25 PM indicated that Resident 195 has short-term memory impairment, impaired decision-making, confusion, and impaired balance. Resident 195's baseline care plan, initiated on [DATE], included the following interventions were planned at the time of the resident's admission on [DATE]: Hipsters at all times except AM and PM care. Admission weights, then daily weights over seven days. Assist of 1 for transfers and grooming. The resident's initial care plan failed to address the resident's fall risk, which was known to the facility as it was included in the hospital discharge documentation, and the resident's need for 100% supervision due to the resident's history of falls. A nursing progress note dated [DATE], at 9:00 PM, indicated that Employee 2, Registered Nurse (RN), noted that Resident 195 had an unwitnessed fall and was observed sitting on the floor in front of the bathroom door in her bedroom. The resident denied pain and had full range of motion to all extremities. The entry indicated that Resident 195 was changed for urinary incontinence 15 minutes prior to the unwitnessed fall. Neurological checks were completed and found to be within normal limits with no change in mentation from baseline. The physician and resident representative were informed, and a new intervention for hipsters at all times was implemented. In a witness statement, dated [DATE], Employee 3, Nurse Aide (NA), indicated that Resident 195 was in her bed in her room when last seen. She was changed 15 minutes prior to the incident. The bed was in the lowest position, and the resident was wearing non-skid socks. Employee 3, NA, indicated that she found the resident in her room outside of the bathroom door sitting on the floor. In a witness statement, dated [DATE], at 9:00 PM, Resident 195 reported that she got up out of bed and went to open the bathroom door (at the time of the fall). A neurological flow sheet indicated that Resident 195's vital signs and neurological checks were implemented every 15 minutes x 4, then every 30 minutes x 2, and then every 2 hours x 11 beginning on [DATE], at 9:00 AM. The documentation indicated that Resident 195 refused all neurological and vital assessments between 3:00 AM and 9:00 AM on [DATE], and was combative with facility staff at time of assessments. Resident 195 refused additional assessments between 11:00 AM and 7:00 PM on [DATE]. A nursing progress note dated [DATE], at 2:13 AM, by Employee 4, RN, indicated that Resident 195 was observed sitting in a chair in the dining room at 1:30 AM. The nursing documentation did not identify why the resident was in the dining room at 1:30 AM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The entry dated [DATE], noted that Resident 195 was observed losing her balance and fell to the floor landing on her right side. Staff were unable to get to the resident before the fall occurred. Employee 4, RN, noted that the resident did not hit her head and was assessed without signs or symptoms of injury. Resident 195 denied pain and discomfort. Nursing noted that the resident had made numerous attempts to self-transfer and is not easily redirected, related to the resident's baseline confusion, noting that Resident 195 becomes agitated and resistive to help when redirection is provided. The physician was notified. An order for a scoot-n-go chair (a mobility device that allows for self-propulsion by moving feet) was received to address safety concerns. A 15-minute check for Resident 195 was initiated on [DATE], at 1:30 AM after this second fall since the resident's admission two days ago, on [DATE] Nursing noted that on [DATE], at 5:44 PM staff administered 2 tablets of Acetaminophen 325 mg. A medication administration record for [DATE] revealed Employee 5, Licensed Practical Nurse (LPN), administered acetaminophen (Tylenol) 2 tablets (325 mg) related to a pain level of 4 out of 10 on [DATE], at 5:44 PM. Documentation indicates that the pain medication was effective. In a skilled charting form, dated [DATE], 9:23 PM, Employee 6, RN, indicated that the resident had notable changes to skin integrity occipital. Nursing documented no further details regarding the changes to skin integrity. The resident had complaints of headaches this PM, relieved with Tylenol. The 15-minute check documentation form revealed that Resident 195 was seated in the hallway from 5:45 PM until 9:00 PM and in her bedroom from 9:15 PM until 9:45 PM. A nursing progress note dated [DATE], at 10:47 PM revealed that Resident 195 was found in the hall sleeping in a chair at 9:40 PM. The entry noted that she vomited and became unresponsive. Vital signs were recorded, the physician was notified, and an order was received to transfer the resident to the hospital. Emergency services were notified, and the resident's representative was informed about the situation. At the time of the survey ending [DATE], the facility was unable to explain the discrepancy between the 15-minute check form indicating Resident 195 was in her bedroom, and the progress note indicating she was found in the hall sleeping in a chair at the same time. There was no fall investigation or other descriptions of the incident or witness statements of the event at the time of the survey ending [DATE]. A facility to hospital transfer form dated [DATE], at 10:15 PM indicated Resident 195 was transferred to the hospital due to being unresponsive. The information was called in to the receiving provider on [DATE], at 9:45 PM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Hospital documentation dated [DATE], at 1:57 AM, indicated that Resident 195 had a fall one day ago of unclear circumstances ([DATE]). No obvious signs of trauma were noted. The hospital documentation indicated that around 10:55 PM last night, she became unresponsive and vomited. She was brought to the emergency department and found to have a large right subdural hematoma with shift. She was reported to be GCS 3 (Glasgow Coma Scale- a score of 3 is the lowest possible score and is associated with an extremely high mortality rate) and was intubated. The documentation indicated a CT scan without contrast of Resident 195's revealed a massive acute right hemispherical subdural hematoma with subfalcine and uncal herniation. Neurosurgical consultation indicated Resident 195 had a non-survivable subdural hematoma. A discharge summary dated [DATE], at 6:00 AM, indicated Resident 195 passed away at the hospital. The cause of death indicated she expired due to a cranial hemorrhage. During an interview on [DATE], at approximately 11:00 AM, the Director of Nursing (DON) confirmed that it is the facility's responsibility to ensure residents receive supervision necessary to prevent falls. The DON confirmed the evidence that showed that Resident 195 was admitted to the facility with a known history of falls and need for increased supervision and also that the facility had assessed the resident upon admission to be at high risk for falls. The DON confirmed Resident 195 had an unwitnessed fall on [DATE]. The DON also confirmed that facility staff were unable to respond in time to prevent Resident 195 from falling again on [DATE]. The facility failed to promptly implement adequate supervision and fall prevention measures from the time of the resident's admission to the facility to prevent these falls which resulted in a serious head injury, and the resident's death. The hospital transfer documentation indicated that the resident needed maximum supervision, which the facility failed to provide to prevent these falls. A review of the clinical record revealed that Resident 9 was admitted to the facility on [DATE], with diagnoses including history of falling, Parkinson's Disease (a chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement), muscle weakness, and tremors. A quarterly Minimum Data Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated [DATE], revealed that the resident was cognitively intact with a BIMS score of 13 and required the use of a walker and wheelchair, as well as requiring partial/moderate staff assistance with sit to stand, chair/bed to chair transfer, toilet transfer and walking, and required substantial/maximum assistance with personal hygiene and a history of falling. The resident's care plan, initiated [DATE], noted that the resident's impaired activity of daily living (ADL) intolerance related to activity intolerance, impaired balance, and Parkinson's Disease. The planned interventions included transfer 1 staff assist with rolling walker, ambulate with 2 staff assist with rolling walker date revised on [DATE]; utilizes scoot-n-go (SNG) chair for mobility date revised on [DATE]. A review of the resident's care plan, initiated [DATE], the resident is at risk for falls related to Parkinson's Disease, gait/balance problems, and a history of hypotension, incontinence and falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A fall risk assessment entitled Fall Risk - V2, dated [DATE], indicated the resident was a high risk for falling with a score of 14 (a score above 10 represents high risk of falling). A Morse Fall Scale dated [DATE], indicated that resident was a high risk for falling with a score of 75 (a score of 45 and higher is at high risk of falling). Current physician orders dated [DATE], were noted to ambulate two assist with rolling walker, and transfer 1 assist with rolling walker. A nurses note dated [DATE], at 3:35 PM noted that staff observed the resident seated on floor in front of scoot and go chair in dining room. Staff witnessed the resident's fall, noting that the resident did not hit head. Nursing noted to continue with every (q) 15-minute safety checks and resident education to ask for help if something is needed. A fall incident report (IR) dated [DATE], noted the fall as described above at 3:00 PM in the dining room with plan to continue the every (q) 15-minute safety checks as previously in place with no other revisions or addition to the resident's fall prevention plan. A nurse's note dated [DATE] at 6:07 AM revealed that during transfer off the commode to a standing position, the resident began to lose her balance and had to be assisted to the floor to a seated position by the nurse aide providing her care. No injuries to report, denies discomfort. RP to be notified, MD notified, new order received for anti-skid strips to be placed in front of the commode. A Physical Therapy (PT) discharge summary dated February 8, 2024, recommended that the resident be a 1 assist with rolling walker (RW) for all transfers and ambulation. A nurse's note dated [DATE], at 8:52 PM indicated that the resident was found on the floor, sitting in front of scoot and go chair in the dining room. Chair was reclined, in proper position. Resident stated she slid out the front of chair. No noted injuries, evidence of trauma or pain related to fall. MD, and RP made aware of fall without injury. Continue q 15-minute safety checks. The fall incident report dated [DATE], noted the fall as described above at 7:45 PM in the dining room with the plan to continue every (q) 15-minute safety checks as previously established. A late entry nurse's note dated [DATE], at 8:30 PM indicated that another resident came to this nurse at 7:25 PM reporting that Resident 9 had fallen. Staff found Resident 9 in dining room on the floor, sitting in front of scoot and go (SNG) sitting Indian style. The resident stated I was reaching to get something off the floor and slipped out of my chair. Upon assessment, no injuries noted. Resident denies pain. RP, MD notified, new order received for dycem (anti-skid material) to top of cushion on SNG chair after this second fall from the scoot and go chair. Placement of a dycem to top cushion on S-N-G chair date was initiated [DATE], according to the resident's care plan. A review of Occupational Therapy (OT) discharge summary dated [DATE] is recommendation that the resident is to be a 1 assist with rolling walker (RW) for all transfers and mobility tasks as noted on February 8, 2024. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of a nurses note dated [DATE], 2:22 AM noted that staff saw Resident 9 resting in bed during midnight rounds, and toileted the resident at this time. At 1:15 AM the resident audio safety alarm was sounding, and staff went to check and witnessed her standing on left side of bed, where she lost her balance and fell on to her right side. The resident sustained a 5 centimeter (cm) x 5 (cm) hematoma (localized bleeding outside of blood vessels, due to either disease or trauma) to right side of forehead. Neurological checks were initiated at time of fall and were found to be within normal limits (WNL). RP to be notified, MD notified, new order received for monitoring and if resident has changes notify him. The specific safety intervention initiated after this fall was have her walker near (available for use) her bed for use during self-transfer related to confusion, although the resident was assessed to require the assistance of one staff for transfers, according to the therapy assessment of [DATE]. During an interview with the Director of Nursing (DON) on [DATE], at approximately 12:50 PM, confirmed Resident 9 is unsafe to self-transfer, and ambulate, and that therapy recommendations are for staff assist of 1 with rolling walker for all transfers, and ambulation. She further confirmed the current physician orders dated [DATE], is to ambulate 2 assist, with rolling walker, and transfer 1 assist with rolling walker. Following survey inquiry regarding the current physician orders dated [DATE], to keep rolling walker at bedside when in bed to encourage resident to utilize if self-transferring. The DON explained that the rationale was if the resident will continue to be non-compliant and self-transfer out of bed, the facility was trying to keep the resident safer by having the walker available for her use. In addition, the DON stated that Resident 9 has been on increased supervision, every (q) 15-minute safety checks, for a long time because of her known history of multiple falls in the facility. The facility failed to timely review and revise the adequacy of the resident's fall prevention measures, including the frequency of staff supervision and the effectiveness of the existing safety measures, to prevent repeated falls for this resident, which increased the potential for injury to the resident. A review of a change in condition follow-up note, dated [DATE], at 7:00 PM revealed that the resident's hematoma remains to the right forehead extending around right eye. Hematoma appears to be progressing. MD aware, order to transfer to emergency room (ER) for evaluation and treatment. A review of a nurses note dated [DATE], at 1:49 AM indicated that call placed to hospital ER for update on resident. Informed they did scans on resident's face, head, and spine with no acute findings; only showing facial swelling. The resident returned to the facility on [DATE], at 10:05 AM. A nurses note dated [DATE], at 8:12 PM indicated that the resident fell 7:00 PM this evening. She apparently got up out of her scoot- and-go and was walking in the dining hall. No staff witnesses to the fall and no apparent injuries. New fall intervention to offer ambulation every day after dinner. A review of a nurses note dated [DATE], at 10:15 PM indicated that the resident was witnessed standing up in the dining hall at 9:30 PM to go to the bathroom. Another resident yelled out, Sit down!. Resident lowered herself to the floor. No apparent injuries. RP, MD aware, new intervention to toilet at 9:30 PM every evening. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Physical Therapy (PT) discharge summary dated [DATE] is recommendation that the resident is to be a 1 assist with rolling walker (RW) for all transfers and ambulation. During an interview with Resident 9 on [DATE], at approximately 11:10 AM, she stated it is her understanding that she is able to ambulate, unassisted. Resident 9 stated that it is her opinion that the facility could use more staff to help the residents, including herself, with activities of daily living. The resident was admitted to the facility with a history of falls, was identified to be at risk for falls, incurred multiple falls within the facility. The facility was aware of the resident's ongoing displays of unsafe behaviors of self-transfers, and attempt to walk unassisted. According to the clinical record, and fall incident reports, the resident incurred seven falls, between [DATE], to the time the survey ended [DATE], with one of the falls resulting in an injury, hematoma, on [DATE]. Of the seven falls, five occurred in the dining room on second (evening) shift. The facility failed to timely implement effective safety interventions including necessary staff supervision, at the level and frequency required, to prevent multiple falls one of which resulted in an injury, hematoma, on [DATE], requiring a transfer to the hospitalER on [DATE], for a resident at risk for falls, with known unsafe behaviors and a history of falls, which was confirmed during interview with the DON on [DATE], at approximately 8:35 AM. Refer F865 28 Pa Code 211.12 (d)(3)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on clinical record review and staff interview, it was determined that the facility failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of pain medication prescribed on an as needed basis and failed to develop a plan of care to address individualized non-pharmacological interventions for pain management prior to the administration of physician ordered as needed pain medication for one resident (Resident 2) of 13 residents reviewed. Findings include: Clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses which included diabetes, right impacted distal femur (Thighbone) periprosthetic fracture with effusion (abnormal collection of fluids in hollow spaces or tissues of the body), fracture of left distal femoral (area of the leg above the knee joint) screw of ORIF (open reduction and internal fixation) with effusion, and left knee laceration. A physician order, initially dated July 9, 2024, was noted for Acetaminophen (pain reliever) 325 mg one tablet by mouth every four hours as needed for pain do not exceed 3000 mg in 24 hours. A physician order initially dated July 9, 2024, for Oxycodone HCL (narcotic analgesic) 5 mg give two tablets by mouth every four hours as needed for severe pain (pain level of 7-10 on numeric 1-10 pain scale) was also noted. A review of Resident 2's July 9 through July 31, 2024, Medication Administration Record (MAR) revealed that staff administered the as needed Acetaminophen 14 times for pain levels which varied 2 to 6 between the dates of July 9 and July 29, 2024. Of the 14 doses of Acetaminophen 325 mg given, all were administered without evidence that non-pharmacological interventions were attempted prior to the medication administration. Further review of Resident 2's July 9 through July 31, 2024, MAR revealed that staff administered the as needed Oxycodone HCL 26 times for pain levels which varied 7 to 10 between the dates of July 9 and July 31, 2024. Of the 26 doses of Oxycodone HCL given, all were administered without evidence that non-pharmacological interventions were attempted prior to the medication administration. A review of the resident's current plan of care initially dated July 21, 2024, revealed a focus concern of pain related to a fracture to the right distal femur (thighbone) with a goal to verbalize relief of pain or ability to cope with incompletely relieved pain. Interventions included administer medications and treatments as ordered, anticipate the resident's need for pain and respond immediately to any complaint of pain, evaluate the effectiveness of pain interventions, and notify the physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain. Further review of Resident 2's care plan failed to identify individualized non-pharmacological interventions to attempt prior to the administration of physician ordered as needed pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON (director of nursing) on August 1, 2024, at approximately 10:30 AM confirmed that there was no documented evidence that non-pharmacological interventions were attempted and proved ineffective prior to administration of prn pain medication. 28 Pa. Code 211.5 (f) Medical records 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, select facility policy, and staff interview, it was determined that the facility failed to demonstrate the physician timely acted upon irregularities identified by pharmacy services during drug regimen reviews for two of the five residents sampled (Residents 30 and 38). Findings include: A review of facility policy titled Medication Regimen Review and Reporting, indicated as last reviewed on March 28, 2024, revealed that it is the facility's policy for issues that require physician intervention, the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his or her rationale for why the recommendation is rejected in the resident's medical record. A clinical record review revealed Resident 30 was admitted to the facility on [DATE], with diagnoses that include depression (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts). A physician's order for Trazodone HCl tablet 150 mg with instructions for Resident 30 to receive 2 tablets by mouth at bedtime for depression major depressive disorder was initiated on July 10, 2023, and discontinued on April 15, 2024. A pharmacy services recommendation summary form dated January 8, 2024, revealed that pharmacy services identified Resident 30 as taking Trazadone 300 mg daily for major depressive disorder since admission in July 2023. Please consider evaluating this medication for any side effects, dose changes, and/or continued use, if clinically appropriate. A clinical record review revealed no actions or responses made by the physician until April 15, 2024. An order note dated April 15, 2024, at 12:10 PM, indicating, as per pharmacy recommendations related to Trazodone, a new order received to discontinue Trazodone 300 mg and start Trazodone 275 mg. A physician's order for Trazodone HCl 50 mg tablet with instructions for Resident 30 to receive 5.5 tablets to equal 275 mg. A clinical record review revealed Resident 38 was admitted to the facility on [DATE], with diagnoses to include Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). A physician's order for Divalproex Sodium Capsule delayed release sprinkle 125 mg with instructions for Resident 38 to receive 3 times a day for dementia was initiated on June 20, 2023, and discontinued on August 22, 2023. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order for Divalproex Sodium Capsule delayed release sprinkle 125 mg with instructions for Resident 38 to receive three times a day for dementia initiated on August 22, 2023, and discontinued on April 16, 2024. A pharmacy services recommendation summary form dated December 11, 2023 revealed that pharmacy services identified Resident 38 has been taking Depakote {Divalproex Sodium} 375 mg three times a day for dementia with agitation since admission in June 2023. Please consider evaluating this medication for any side effects, dose changes, and/or continued use, if clinically appropriate. A clinical record review revealed no actions or responses made by the physician until April 16, 2024. A physician's order for Divalproex Sodium Capsule delayed release sprinkle 125 mg with instructions for Resident 38 to receive 2 capsules by mouth for dementia was initiated on April 16, 2024. A progress note dated April 17, 2024, at 1:52 PM indicating Depakote decreased to 125 mg from 3 times a day to two times a day. The resident does not show any signs or symptoms of increased agitation, changes in mood, or adverse reactions. During an interview on July 31, 2024, at approximately 1:00 PM, the Nursing Home Administrator (NHA) and Director of Nursing were unable to provide documented evidence to demonstrate the physician timely acted upon or responded to irregularities identified by pharmacy services during drug regimen reviews for Residents 30 and 38. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (d)(3) Nursing services. 28 Pa. Code 211.2 (d)(3) Medical Director

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on clinical record review and staff interview, it was determined facility failed to fully implement a hospice plan of care for one out of two resident reviewed under hospice care (Resident 21). Findings include: A review of the clinical record revealed Resident 21 was most recently admitted to the facility on [DATE], with diagnoses to include cerebral infarction (stroke), right sided hemiplegia - hemiparesis, chronic kidney disease (CKD), and gastro-esophageal reflux disease (GERD). A review of current physician orders dated July 1, 2024, indicated the resident was admitted to hospice services for end stage chronic kidney disease, and stroke. A review of Resident 21's Significant Change MDS dated [DATE], Section O, Special Treatments, Procedures, and Programs, Question O0100K: Hospice care was triggered, identifying service was provided While a Resident. Review of Resident 21's plan of care, conducted during the survey ending August 1, 2024, revealed that the resident's plan of care failed to indicate a plan of care by the facility for hospice care goals and interventions. During an interview with the Director of Nursing (DON) on July 31, 2024, at approximately 9:40AM, she confirmed the facility failed to fully implement a hospice plan of care for Resident 21. 28 Pa. Code 211.12 (d)(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** 39235 Based on review of select facility policy, clinical records, and incident reports and staff interviews, it was determined that the facility failed to demonstrate the implementation of ongoing QAPI programs, to include the use of systems for investigating and analyzing the root cause of adverse events, as evidenced by multiple falls incurred by one resident out of four sampled (Resident 9). Findings include: Review of the facility policy entitled Quality Assurance and Performance Improvement Policy and Procedure last reviewed March 28, 2024, revealed, the facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, which will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. The facility will maintain effective systems to identify, collect, and used data and information from all departments, including the facility assessment, and will use this information to develop and monitor performance indicators. The facility will develop, monitor, and evaluate performance indicators, including a description of that methodology and frequency for such development, monitoring, and evaluating. Facility adverse event monitoring will include the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility and how the facility uses the data to develop activities to prevent adverse events. A review of the clinical record revealed that Resident 9 was admitted to the facility on [DATE], with diagnoses including history of falling, Parkinson's Disease (a chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement), muscle weakness, and tremors. A quarterly Minimum Data Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 9, 2023, revealed that the resident was cognitively intact with a BIMS score of 13 and required the use of a walker and wheelchair, as well as requiring partial/moderate staff assistance with sit to stand, chair/bed to chair transfer, toilet transfer and walking, and required substantial/maximum assistance with personal hygiene. Section J, Health Conditions, Question J1800: indicated a history of falling. A review of the resident's care plan date-initiated August 22, 2018, the resident's impaired activity of daily living (ADL) intolerance related to activity intolerance, impaired balance, and Parkinson's Disease. The planned interventions included transfer 1 staff assist with rolling walker, ambulate with 2 staff assist with rolling walker date revised on March 6, 2023. Utilizes scoot -n-go (SNG) chair for mobility date revised on July 15, 2024. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's care plan date-initiated August 22, 2018, the resident is at risk for falls related to Parkinson's Disease, gait/balance problems, and a history of hypotension, incontinence and falls. The planned interventions included dycem to top cushion on SNG chair date initiated April 30, 2024, audio alarm in room to alert staff when attempting to independently transfer date initiated October 6, 2023, non-compliant with asking for assistance, wears slipper socks or non-skid footwear, education on risks of self transfer, and hipsters at all times except with AM and PM care date revised July 15, 2024, offer ambulation after dinner date initiated June 19, 2024, and anti-skid strips to right, and left side and in front of commode date revised July 15, 2024. A review of a fall risk assessment entitled Fall Risk - V2, dated March 16, 2018, indicated the resident was a high risk for falling with a score of 14 (a score above 10 represents high risk of falling). A review of a document entitled Morse Fall Scale dated November 27, 2023, indicating the resident was a high risk for falling with a score of 75 (a score of 45 and higher is at high risk of falling). A review of a nurses note dated December 26, 2023 at 1535 hours (3:35 PM) stating observed resident sitting on floor in front of scoot and go chair while in dining room. Continue with every (q) 15-minute safety checks and resident education to ask for help if something is needed. A review of facility fall incident report (IR) dated December 26, 2023, revealed the fall as described above at 1500 (3:00 PM) in the dining room. The specific safety intervention(s) initiated were to continue every (q) 15-minute safety checks (as previously established). A review of a nurses note dated January 1, 2024 at 0607 hours (6:07 AM) revealing that during transfer off the commode to a standing position, resident began to lose her balance and had to be assisted to the floor in a seated position by Nursing Assistant (NA) providing her care. A review of facility fall incident report (IR) dated January 1, 2024, revealed the fall as described above. The specific safety intervention(s) initiated were to add anti-skid strips to be placed in front of commode. A review of Physical Therapy (PT) discharge summary dated February 8, 2024, is recommendation that the resident is to be a 1 assist with rolling walker (RW) for all transfers and ambulation. A review of a nurses note dated March 17, 2024, at 2052 hours (8:52 PM) indicating the resident was observed on floor, sitting in front of scoot and go chair. Continue q 15-minute safety checks. A review of facility fall incident report (IR) dated March 17, 2024, revealed the fall as described above at 1945 hours (7:45 PM) in the dining room. The specific safety intervention(s) initiated were to continue every (q) 15-minute safety checks (as previously established). A review of a nurses note, late entry, dated April 29, 2024, at 2030 hours (8:30 PM) indicating another (peer) Resident came to this nurse at 1925 hours (7:25 PM) stating Resident 9 had fallen. Resident found in dining room sitting in front of scoot and go (SNG) sitting Indian style. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility fall incident report (IR) dated April 29, 2024, revealed the fall as described above at 1925 hours (7:25 PM) in the dining room. The specific safety intervention(s) initiated were to dycem (anti-skid material) to top of cushion. A review of Occupational Therapy (OT) discharge summary dated May 28, 2024 is recommendation that the resident is to be a 1 assist with rolling walker (RW) for all transfers and mobility tasks. A review of a nurses note dated June 1, 2024, at 0222 hours (2:22 AM) indicating Resident 9 was seen resting in bed during midnight rounds, and toileted at this time. At 0115 (1:15 AM) audio alarm was sounding, and staff went to check and witnessed her standing on left side of bed, where she lost her balance and fell on to her right side. During assessment noted a 5-centimeter (cm) x 5 (cm) hematoma (localized bleeding outside of blood vessels, due to either disease or trauma) to right side of forehead. A review of facility fall incident report (IR) dated June 1, 2024, revealed the fall as described above. The specific safety intervention(s) initiated were to have her walker near (available for use) her bed for use during self-transfer related to confusion. A review of a change in condition follow-up note, dated June 2, 2024, at 1900 hours (7:00 PM) indicating the resident voices no complaints of any pain or discomfort related to the fall. Hematoma remains to the right forehead extending around right eye. Hematoma appears to be progressing. No complaints of any headache or blurred vision. Neurological checks at baseline. MD aware, order to transfer to Hospital emergency room (ER) for evaluation and treatment. A review of a nurses note dated June 3, 2024, at 0149 hours (1:49 AM) indicating call placed hospital ER for update on resident. Informed they did scans on resident's face, head, and spine with no acute findings. Only showing facial swelling. Resident is discharged but remains at ER waiting transport back to facility. RP aware. A review of a nurses note dated June 3, 2024, at 1005 hours (10:05 AM) indicating the resident returned to facility, is awake and alert with confusion. A review of a nurses note dated June 19, 2024, at 2012 hours (8:12 PM) indicating the resident fell at 1900 (7:00 PM) this evening. She apparently got up out of her scoot- and-go and was walking in the dining hall. A review of facility fall incident report (IR) dated June 19, 2024, revealed the fall as described above at 1900 hours (7:00 PM) in the dining room. The specific safety intervention(s) initiated were to offer ambulation after dinner. A review of a nurses note dated July 4, 2024, at 2215 hours (10:15 PM) indicating the resident was witnessed standing up in the dining hall at 2130 (9:30 PM) to go to the bathroom. Another resident yelled out, Sit down!. Resident lowered herself to the floor. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bonham Nursing and Rehabilitation Center	477 Bonnieville Road Stillwater, PA 17878

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility fall incident report (IR) dated July 4, 2024, revealed the fall as described above at 2140 hours (9:40 PM) in the dining room. The specific safety intervention(s) initiated were to toilet the resident at 2130 hours (9:30 PM). A review of Physical Therapy (PT) discharge summary dated July 5, 2024 is recommendation that the resident is to be a 1 assist with rolling walker (RW) for all transfers and ambulation. During an interview with the Director of Nursing (DON) on July 31, 2024, at approximately 12:50 PM, confirmed there was no additional documentation pertaining to the facilities efforts investigating and analyzing the data collected in an effort to obtain the root cause of adverse events (falls) at the time of the review, and that resident 9 is unsafe to self-transfer, and ambulate. In addition, the DON stated that Resident 9 has been for a long time on increased supervision, every (q) 15-minute safety checks, because of her known history of multiple falls in the facility. The resident was admitted to the facility on [DATE], with a history of falls, was identified to be at risk for falls, incurred multiple falls within the facility, and was aware of the resident's ongoing displays of unsafe behaviors of self-transfers, and attempt to walk unassisted. According to the clinical record, and fall IR's the resident incurred seven falls, between December 2023, to the time the survey ended August 1, 2024, with one of the falls resulting in an injury, hematoma, on June 1, 2024. Of the seven falls, five occurred in the dining room on second (evening) shift. There was no evidence that the facility had identified the pattern, nor the necessary staff supervision, at the level and frequency required, for a resident with known unsafe behaviors. At the time of the survey ending August 1, 2024, the facility had not yet effectively addressed the resident's behavior of falling from her SNG chair, in the dining room on second (evening) shift, which had resulted in multiple falls and injury, hematoma, which was confirmed during interview with the DON on August 1, 2024, at approximately 8:35 A.M. There was no evidence at the time of the survey that the facility demonstrated an effective QAPI program to include outcomes of quality of care and quality of life by investigating the incident and thorough documentation to support their analysis of the data collected and any corrective actions developed and implemented. Refer F 689 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(4) Management 28 Pa. Code 211.12 (c) Nursing Services