STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396107	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ann's Choice	16000 Ann's Choice Way Warminster, PA 18974

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 06525 Based on review of clinical record, review of policy and procedure and interview with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of initiated emergency transfers and dischargers for three of four residents reviewed (Residents R59, R111, R60) Findings include: A review of the policy titled skilled nursing initiated transfer/discharge date d June, 2021 revealed that it was the responsibility of the facility staff to send a timely copy of the notice of facility initiated resident transfers or discharges to the Ombudsman or other State required agencies. Clinical record review for Resident R60 revealed she was readmitted to facility on August 19, 2024 status post hospitalization for hypotension (high blood pressure) and heart failure. Clinical record review for Resident R59 revealed he was hospitalized on [DATE] with septic shock. Clinical record review for Resident R111 revealed that this resident was atmitted to the hospital on August 1, 2024 with osteopenia and fracture involving the left femoral neck (hip) with mild displacement. Interview with the social worker, Employee E13 and the director of nursing, Employee E2 at 1:30 p.m., on October 10, 2024 confirmed that the facility was unable to provide a list of facility-initiated transfer and discharge notices to the State Long-term Care Ombudsman for Residents R59, R111, R60 upon request, on October 10, 2024. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(2) Management

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43923 Based on review of facility policy, review of facility documentation, and review of clinical records, it was determined that the facility failed to develop a person-center, comprehensive care plan related to respiratory care for one of 16 residents reviewed (Resident R1). Findings Include: Review of facility policy Care/Service Plans, undated 9/2012, revealed each guest/resident will have an individualized Care/Service plan developed. Care/Service Plans will included guest/resident preferences, strengths, routines, personal and cultural preferences and choices as well as clinical needs. Review of the admission record indicated Resident R1 was admitted to the facility on [DATE] with the following diagnoses hypertension (high blood pressure), stage 1 through stage 4 chronic kidney disease, chronic systolic (congestive) heart failure (a condition where the heart's ability to pump blood efficiently is impaired due to weakened or damaged heart muscle, leading to a buildup of fluid in the lungs or other parts of the body), paroxysmal atrial fibrillation (a type of irregular heart rhythm), atherosclerotic heart disease of native coronary artery without angina pectoris, mild cognitive impairment of uncertain. Review of Resident R1's current physician order dated, September 23, 2024 indicated oxygen L/min (2) intranasal administer via NC nasal cannula @ HS (night). During an interview on Ocotber 7, 2024 at 7:03 a.m., Registered Nurse (RN) Unit Manager, Employee E15, confirmed that Resident R1 had an oxygen level set at 4 liters. Review of Resident R1's care plan revealed no documented evidence the facility developed or implemented a person-centered, comprehensive care plan with measurable objectives and timetables to address the resident's respiratory care. During an interview on 10/09/24 at 2:17 p.m. Registered Nurse (RN) Unit Manager, Employee E15, confirmed that Resident R1 did not have a person-centered, comprehensive care plan with measurable objectives and timetables to address the resident's respiratory care. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12(d)91) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on review of facility documentation, review of closed clinical record, and staff interviews, it was determined that the facility failed to provide adequate supervision which resulting in an elopement for one of 4 residents reviewed (Resident R161). Findings Include: Review of facility policy Elopement Risk Assessment , undated June 2012, revealed The Elopement Risk Assessment assists in the identification of residents with a potential risk of elopement from the facility. The assessment is completed at the time of admission, re-admission, and every six-months and/or with any significant change in a resident's condition potentially impacting their risk of elopement. Review of the clinical record indicated Resident R45 was admitted to the facility on [DATE], and had diagnoses including unspecified dementia, moderate with psychotic disturbance, mild cognitive impairment of uncertain or unknown etiology as of April 13, 2022. Review of Resident R161's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated December 20, 2023, revealed a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment indicated a score of 4 which revealed that the resident was severe impaired. Review of a facility submitted report dated December 18, 2023, indicated that Resident R161 eloped on December 18, 2023, at 3:31 p.m. from the facility and was safely located in the parking lot in front of the building and redirected at 3:40 p.m same day. Review of Resident R161's comprehensive care plan dated December 14, 2023, revealed the Resident R161 had a goal of I will be able to explore my neighborhood I will have someone walk with me when able outside I will be safe while exploring. On October 10, 2024, at 9:31 a.m., during an interview with the Director of Nursing, Employee E2, it was revealed that Resident R161 had a holistic assessment upon admission on December 14, 2023, which included an elopement risk section. The holistic assessment did not indicate that Resident R161 exhibited elopement behaviors upon admission, though it did document a prior history of such behaviors while residing in the Assisted Living Program from July 2023 to December 6, 2023. Based on this assessment, Resident R161 was not deemed an elopement risk at the time of admission, and therefore, a WanderGuard (device place on the wrist or ankle that automatically lock designated doors) was not initiated. Employee E2 confirmed a specific Elopement Risk Assessment was not completed because Resident R161 was not rated as at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review indicated that R161 had been residing in the facility's Assisted Living Program and did have a WanderGuard due to being an elopement risk. However, during his hospitalization , the WanderGuard was removed and was not considered upon his admission to the Skilled Nursing Unit. It was also revealed that Resident R161 had a documented history of exit-seeking behaviors. According to the internal investigation on December 18, 2023, at 4:59 p.m., the receptionist, Employee E17, noted that he apparently didn't have his WanderGuard on since returning from the hospital on 12/14/23. I did not hear or see him as he exited the building. Employee E2 further explained that upon admission, Resident R161was not highly ambulatory and did not display exit-seeking behaviors, which led the facility to conclude that he was not a high elopement risk. In an interview on October 10, 2024, at 10:39 a.m., Receptionist Employee E17, who was on duty at the front desk on December 18, 2023, stated, On Monday, December 18, 2023, I was in a conference room meeting with my manager, but the door was open so I could see the front desk and hear the phone. Resident R161 must have walked past the front desk and exited the building about ten minutes after I entered the conference room. He was not wearing a WanderGuard at the time, and I don't believe he was supposed to have one. I keep a list of all the residents with WanderGuards. I only know that he was found outside in front of the building and brought back inside. Employee E17 further explained, When [Resident R161] lived in assisted living, he would often come to the front desk asking where his car was, saying he had an appointment. He used to wear a WanderGuard during that time. However, after [Resident R161] was hospitalized , the WanderGuard was removed, and I didn't realize it wasn't put back on when he returned. On October 10, 2024, at 11:36 a.m., during an interview with the Director of Nursing, Employee E2, it was further revealed that Resident R161 had been a resident in the Assisted Living Program and had temporarily worn a WanderGuard for safe supervision until transitioning to the Memory Care Unit. According to the Assisted Living Program records, Resident R161 had a WanderGuard from July 2023 until his hospitalization on [DATE]. Resident R161 was then admitted to the Skilled Nursing Unit on December 14, 2023, eloped on December 18, 2023, and passed away on December 21, 2023. In an interview on October 10, 2024, at 1:18 p.m. with the Administrator, Employee E1, and the Director of Nursing, Employee E2, it was confirmed that Resident R161 had a prior history of elopement behavior and had previously worn a WanderGuard, which should have qualified him as an elopement risk. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12 (d)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on clinical record review and interviews with staff, it was determined that the facility failed to obtain orders for urinary catherization for one of 16 residents reviewed (Resident R45). Findings include: Review of facility policy Urinary Catheters, undated July 2012, revealed to provide urinary catheter care for a guest/resident in accordance with nursing standards of practice and minimize the spread of infection. Review of the clinical record indicated Resident R45 was admitted to the facility on [DATE] and had diagnoses including tubule-interstitial nephritis (kidney disorder characterized by inflammation of the tubules and surrounding interstitial tissue), aftercare following joint replacement surgery, presence of left artificial knee join, sepsis, other abnormalities of gait and mobility, spinal stenosis , vascular dementia, retention of urine, urinary tract infection. Review of Resident R45's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated September 16, 2024, revealed a Brief Interview for Mental Status (BIMS- is a screening test that aides in detecting cognitive impairment indicated a score of 3 which revealed that the resident was severe impaired. On October 8, 2024, at 10:11 a.m. an observation/interview revealed Resident R45 had an indwelling urinary catheter in place. The urinary catheter dignity bag on the side of the bed which was facing the window, and it was emptied. A review of the clinical record for Resident R45 revealed that there was no order physician order for the resident to have an indwelling urinary catheter. On October 10, 2024, at 1:27 p.m. an interview with the license nurse, Employee E16 confirmed that Resident R45 does not have a physician order for an indwelling urinary catheter. On October 10, 2024, at 1:34 p.m. an observation with Employee E16 revealed that Resident R45 continued to have an indwelling urinary catheter in place. On October 10, 2024, at 1:36 p.m., during an interview with Licensed Nurse Unit Manager Employee E15, it was confirmed that Resident R45 did not have a physician's order for the indwelling catheter. Employee E15 stated, I can't be here 24 hours, and was unable to provide an explanation for the lack of a physician's order, other than the facility's failure to obtain one for the urinary catheter. 28 Pa Code 211.12(d)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923 Based on review of facility policy, observations, interviews, and clinical record review, it was determined that the facility failed to provide oxygen level in accordance with physician's orders for one of two residents (Residents R1). Findings include: Review of the admission record indicated Resident R1 was admitted to the facility on [DATE] with the following diagnoses hypertension (high blood pressure), stage 1 through stage 4 chronic kidney disease, chronic systolic (congestive) heart failure (a condition where the heart's ability to pump blood efficiently is impaired due to weakened or damaged heart muscle, leading to a buildup of fluid in the lungs or other parts of the body), paroxysmal atrial fibrillation (a type of irregular heart rhythm), atherosclerotic heart disease of native coronary artery without angina pectoris, mild cognitive impairment of uncertain. Review of Resident R1's current physician order dated, September 23, 2024 indicated oxygen L/min (2) intranasal administer @2L via NC (nasal cannula) @ HS (night). During an observation on October 7, 2024 at 7:03 a.m. Resident R1 was observed to have 4-liter oxygen level. During an interview on October 7, 2024 at 7:03 a.m., Registered Nurse (RN) Unit Manager, Employee E15, confirmed that Resident R1 had an oxygen level set at 4 liters. During an interview with the Administrator, Employee E1 and Director of Nursing, Employee E2 on October 7, 2024 at approximately 2:30 p.m. it was confirmed that facility did not ensure Resident R1 had an appropriate oxygen rate. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.