STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395525	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy Hill Post Acute Nursing & Rehabilitation LLC	1401 Ivy Hill Road Philadelphia, PA 19150

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews with residents and staff and reviews of policies and procedures, it was determined that for one of two residents reviewed that the interdiciplinary care planning team failed to assess each resident for self adminitration of medications and determine if the practice was clinically appropriate and safe in accordance with their residents rights. (Resident R94) Findings include: A review of the undated facility policy titled self-medication administration revealed that it was each resident's right to manage their medications independently within the nursing home. The policy indicated that the facility was responsible for assessing each resident to deem if the resident was capable of safely managing their own medications. Clinical record review for Resident R94 revealed a quarterly comprehensive assessment dated [DATE] that indicated this resident was cognitively intact, had no swallowing problems with foods or fluids. The assessment also indicated that the resident had adequate vision, was able to follow directs and had no functional limitations of upper extremities. Interview with Resident R94 at 2:30 p.m., on March 24, 2025 revealed that the resident does order medications (airbone gummies, centrum silver, finasteride, folic acid, glipizide, glycolax powder, docusate sodium, ascorbic acid, ferrous sulfate) to be delivered to the facility or that the facility pharmacy delivers to the facility for him. Resident R94 reported that he was a retired pharmacist and he was interested in administering medications to himself. The resident was understanding that he would have to be provided with a locked bed side cabinet to secure the medications from staff and other residents. Inreview with the licensed practical nurse, Employee E24 at 2:40 p.m., on March 24, 2025 confirmed that Resident R94 had been given the opportunity of assessment by the interdisiplinary care team, to the determine his ability to self administer medications. The licensed nurse, Employee E24 reported being aware that the resident had been requesting to self administer medications, since admission to the facility on December 13, 2024. The licensed practical nurse, Employee E24 verified that there was no care plan developed for Resident R94 to self administer medications as he desired. 28 PA. Code 211.10(a)(b)(c)(d) Resident care policies 28 PA. Code 211.12(d)(1)(3)(5) Nursing services (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 PA. Code 201.29(a) Resident rights

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and resident and staff interviews, it was determined that the facility failed to provide adequate housekeeping and maintenance services to ensure a clean, comfortable, and homelike environment for three of three nursing units observed (first floor, second floor, third floor). Findings include: On March 24, 2025, at 12:57 p.m., Unit Manager Employee E19 confirmed that Resident R37 in room [ROOM NUMBER]-2 did not have access to a locked drawer at his bedside to store his personal belongings. Resident R37 had filed a grievance on January 3, 2025, regarding the missing $80, which was not reimbursed, and had been promised a locked drawer to secure his personal items. Observation on March 25, 2025 at 11:44 a.m. in room [ROOM NUMBER] revealed Resident R15 lying in bed in a fetal position. Interview with Resident R15 on March 25, 2025 at 11:45 a.m. revealed room [ROOM NUMBER] did not have a working heating unit. Resident R16 further stated the middle part of her bed was broken and she is unable to lay comfortably. Interview with Certified Nursing Assistance, Employee E13, confirmed Resident R15's bed and heating unit were broken. Observation of Resident R6 and R89's room [ROOM NUMBER] on March 24, 2025 at 11:30am, revealed unmaintained, leaking windowsill. Windowsill appeared dirty with thick dust and large dried clumps of patching plaster dripped along sill with no evidence of an attempt to clean up. Further observation revealed multiple soiled ceiling tiles. Observation of resident room [ROOM NUMBER] was confirmed by Maintenance Director, Employee E20, on March 24, 2025 at 11:44 AM. Observation of Resident R52 and R66's room [ROOM NUMBER] on March 24, 2025 at 11:15 AM revealed multiple soiled ceiling tiles. Observation of resident room [ROOM NUMBER], was confirmed by Maintenance director, Employee E20, on March 24, 2025 at 11:45 AM. On March 25, 2025, at 10:30 a.m. a resident council meeting was held with 8 alert and oriented residents (R31, R70, R89, R71, R34, R34, R127, R94) who reported that they do not have locks on their drawers to keep their personal belonging. On March 25, 2025, at 12:48 p.m., an observation was made with Maintenance Director, Employee E20, who confirmed that the residents in the rooms 318-2, 303-2, 215-2, 300-1, 107-2, 308-1, 112-2, 231-1did not have access to locked drawers for storing their personal belongings. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of first floor dining room on March 25, 2025 at 11:32 AM revealed multiple soiled ceiling tile dispersed throughout dining area. 28 Pa Code 201.18(b)(1)(3) Management.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on the review of clinical records, facility documentation, facility policies, and interviews with resident and staff, it was determined that the facility failed to demonstrate evidence that a grivance was promptly documented and resolved for one of 26 resident records reviewed. (Resident R95) Findings Include: The facility will fully investigate and respond to all concerns or complaints regarding patient/resident care and/or treatment. The patient/resident/ resident representative has the right to file a grievance orally, in writing, or anonymously. All grievances will be responded to within 48-72 hours, and in writing if requested. On March 24, 2025, at 12:55 p.m., an interview was conducted with Resident R37, who reported that $80 had gone missing in January 2025. The facility investigated the concern but did not issue a refund, stating that the amount was not documented on the resident's inventory sheet. Resident R37 also mentioned that the facility had promised to provide a locked drawer for storing his personal belongings. At 12:57 p.m. on the same day, Unit Manager Employee E19 confirmed that no locked drawer was available at Resident R37's bedside for the storage of personal items. Grievance was not resolved. On March 25, 2025, at 10:30 a.m. a resident council meeting was held with 8 alert and oriented residents (R31, R70, R89, R71, R34, R34, R127, R94) who reported that resolution of the grievances are not communicated to the residents. Resident R94 reported that he requested for the resolution of his grievance would be given to him in writing and facility declined. On March 26, 2025, at 2:15 p.m., an interview was conducted with the family representative of Resident R108, who expressed concern that the resident's clothing was missing. The representative explained that they personally bring new clothing, label it, and place it in the resident's closet. However, they were unaware that the facility is supposed to complete an inventory sheet for every item brought to Resident R108. The representative also reported that, during a visit two days ago, the resident was seen wearing someone else's clothing for two consecutive days. A review of the grievance which was filed by a resident's R95 family representative on January 22, 2025, listed missing clothing items such as black & gray skinny jeans, black hoodie, 1 black long sleeve thermal, plain black short sleeve t-shirt, burgundy pants with pink paw prints, fresh empire black t-shirt with lime green, gray long sleeve with pink stirp around collar, burgundy pants stretchy. Grievance noted that items were found, and grievance resolved. A review of the inventory sheet dated November 27, 2024, none of the above missing items were listed on the inventory sheet. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 28, 2025, at 10:05 a.m., an observation was conducted with the Housekeeping Supervisor, Employee E16, regarding Resident R95's clothing. It was noted that the resident had additional items in her closet, none of which were listed on the inventory sheet. E16 is responsible for labeling the clothing and managing its location when items go missing as part of the grievance process. However, R16 does not complete the inventory sheet. It was also confirmed that some of Resident R95's clothing, such as a black winter jacket, had been labeled by the family using tape, which can easily come off. The clothing should have been labeled by the facility instead with facility's ironing labeling process. On March 28, 2025, at 10:28 a.m., an interview was conducted with Social Worker Director, Employee E3, who confirmed that she does not educate residents or their representatives about the clothing inventory process, nor does she complete the inventory sheet. E3 handles grievances and reported that families are notified about the clothing inventory process upon admission, based on the facility's signage at the receptionist desk. E3 further confirmed that in the case of Resident R95's grievance, dated January 22, 2025, the missing clothing had not been originally documented on the resident's inventory sheet. On March 28, 2025, at 10:36 a.m. an admission director, Employee E18 was interviewed who reported that she does not educate families about the inventory sheet and personal belongings upon admission. On March 28, 2025, at 10:43 a.m., an interview was conducted with the receptionist, Employee E17, who reported that when families bring in bags of clothing, she asks if the items are for the resident. If the family confirms, she provides them with an Inventory of Personal Possessions form to complete and checks the clothing against the form. E17 then hands the clothing bag, along with the form, to the nursing assistant or unit manager for the resident, who is responsible for completing the inventory sheet and placing it in the resident's hard chart. However, if the family handles the resident's laundry, the receptionist does not check the clothing or provide the Inventory of Personal Possessions form. In this case, the family simply drops off the clothing directly in the resident's room, and the clothing is neither labeled nor added to the inventory list. On March 28, 2025, at 10:50 a.m., a follow-up interview was conducted with the Social Work Director, Employee E3, who acknowledged that there is a broken process with the inventory sheet. There is no documentation for clothing when families handle the laundry for the resident, nor is there a clear process to track and locate the clothing, as was the case with Resident R95. 28 Pa. Code 201.18 (b)(1)(3)(2.1)(4) Management 28 Pa. Code 201.29 (a) Resident Rights

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations of care and services, interviews with residents and staff and reviews of policies and procedures, it was determined that the facility failed to ensure that three of 38 residents were protected from inappropriate sexual behaviors from one resident. (Residents R63, R44, R82) Findings include: A review of the undated facility policy titled resident rights, abuse, neglect, mistreatment or misappropriation of resident property revealed that it was the responsibility of the facility to prevent abuse, neglect, mistreatment or misappropriation of resident property. All staff were responsible for reporting and investigating abuse including resident to resident abuse. All employees would be screened for convictions of abuse. Residents would be screened by the social worker for personal or family history of abuse. All employees, including management staff and volunteers would receive training upon orientation and annually about recognizing, reporting and prevention of abuse. The training was to include how staff was to report their knowledgement of allegations of abuse without fear of reprisal. The policy indicated that all residents and families and staff were encouraged to report concerns of abuse without fear of retribution. The facility administration was responsible to provide feedback regarding the concern that was expressed. That all staff and volunteers would be trained to immediately report an observed/suspected incident of abuse. The facility had a zero tolerance for resident abuse, neglect, mistreatment or misappropriation of resident property by anyone including staff members, other residents, consultants, volunteers, and staff of other agencies serving the residents. Any witness to abuse must submit a report immediately to the employee's supervisor. The witness must report to the nursing supervisor the following information: name of the resident involved, date and time of the incident, location of the incident, the perpetrator, names of other witnesses to the incident, type of abuse. The nursing supervisor was then responsible for examining the resident. The nursing supervisor was responsible for recording the incident of abuse or alleged abuse in the residents' clinical record. The nursing supervisor was to notify the abuse coordinator (the Nursing Home Administrator and Director of Nursing). During the investigation the perpetrator will be supervised or suspended, pending the results of the investigation. The policy indicated that an incident report (documentation) would be completed for the abuse event and the physician would examine the resident as indicated. The abuse coordinator would be responsible for complete a comprehensive investigation of the alleged abuse. The investigation would be recorded and reported to State Agencies as required with corrective actions taken. The abuse coordinator would contact the resident or responsible party with the results of the abuse investigation report and corrective actions taken. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R44's quarterly Minimum Data Set (MDS- a federal mandated assessment for all residents) dated December 25, 2024, revealed Resident R44 was admitted into the facility June 2, 2023, with diagnoses of bipolar disorder (condition in which a person has periods of depression and periods of being extremely happy), human immunodeficiency virus and dysphasia (problem swallowing). Resident R44's cognition was evaluated as a BIMS (brief interview mental status) score of 10 indicating resident R44 has moderate cognitive impairment and independent with mobility. Review of Resident R44's November 2024 physician orders revealed an order for resident to be checked every hour initiated November 6, 2024. Continued review of the physician orders also revealed an order obtained on January 13, 2025 for one to one supervision at all times. Review of nursing notes date November 6, 2024, revealed that Resident R44 ordered for one hour checks. The resident was observed several times throughout the shift coming in and out of resident's rooms, and community rooms showing inappropriate sexual behaviors. Continued review of Resident R 44's clinical record revealed multiple room changes from November 2024 through January 2025 as follows: November 11, 2024 room [ROOM NUMBER], December 3, 2024 room [ROOM NUMBER], December 23, 2024, room [ROOM NUMBER], January 8, 2025 room [ROOM NUMBER], January 9, 2025 room [ROOM NUMBER], January 11, room [ROOM NUMBER]. There was no documented evidence in the resident's clinical record of the rationale for the room changes. Review of psychology note dated February 21, 2024, noted that the resident displayed hypersexual thoughts and behaviors. The clinician informed unit nurse manager and voiced the concerns that he is fixated on having sex and has made comments about wanting to act when his urges. Review of resident's care plan dated December 19, 2025, revealed cognitive loss related to traumatic brain injury resident has a BIMS score of 10 with interventions to include, speaking in a calm positive manner, do not rush or supply words, and identify self when speaking to resident. Continued review of Resident R44's care plan revealed that Resident R44 has sexual inappropriate behavior and sexual abuse allegations dated December 24, 2025, with interventions to continue 1:1 supervision. Resident R44 has been observed displaying sexual inappropriate behaviors, touching of genitals, grabbing at staff in appropriate areas, inappropriate sexual comments toward staff dated December 19, 2024. Interview with nursing aide, Employee E8 on March 24, 2025, at 10:15 a.m. revealed that this employee had witnessed Resident R44 taking off Resident R63's underwear. Resident R63 does not have the cognition to consent. Employee 8 stated that she went directly to the nurse unit manager and reported it last January. Employee E8 stated that Assistant Director of Nursing and Director of Nursing and Nursing Home Administrator were all made aware of the incident. Employee E8 stated that she is aware of two other occasions that Resident R44 was caught having inappropriate sexual behavior. Continued interview with nurse aide, Employee E8 stated that on another occasion the visiting volunteer pastor had caught Resident R44 touching a resident's breast during the service. The volunteer pastor immediately reported the incident to staff. Interview with volunteer pastor, Employee E10 on March 26, 2025, at 3:00 p.m. revealed that Employee E10 stated that he remembered an incident that when he saw Resident R44 with his hand on Resident R82's breast, over her sweater. Employee E10 stated that resident R44 is no longer allowed to attend services, he is very uncomfortable with resident R44's gestures towards the pastor's wife. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R78's MDS (Minims Date Set) dated January 7, 2025, in Section C- cognitive patterns, revealed that resident has a BIMS (brief interview for mental status) of 12 (moderately impaired). Review of Resident R78's progress note dated December 15, 2025 at 1:18PM, revealed resident is cognitively intact. Interview with Resident R78 on March 27, 2025 at 9:11 a.m., revealed that he had witnessed multiple occasions of sexually inappropriate behaviors of Resident R44 towards Resident R82 in common areas. These behaviors included Resident R44 touching the leg of Resident R82. Resident R44 acting sexually toward Resident R82. Resident R44 grabbing Resident R82 from behind and wrapping his arms around her. Resident R44 giving little gifts to Resident R82. Staff would tell Resident R44 to leave the common area when inappropriate behaviors observed, sometimes other residents would intervene as well. Interview with nursing aide, Employee E30 on March 25 at 3:45 p.m. when question why Resident R44 was on one to one supervision she stated that he is touchy with other residents Interview with nurse aide, Employee E31 on March 25 , 2024 at 3:55p.m. he touches residents inappropriately Review of Resident R63's quarterly MDS dated [DATE] indicated that this resident had diagnoses of adjustment disorder with anxiety and dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking) with agitation. The assessment indicated a BIMS of 3 which indicated severe cognitive impairment. The assessment indicated that this resident used a wheelchair, required staff supervision and contact guard (minimal physical support) with chair to bed/bed to chair transfers. The resident was assessed with bowel and bladder incontinence. Interview with a nurse aide, Employee E8 on March 24 and March 26, 2025 during the seven to three nursing tour of duty revealed that this employee witnessed Resident R44 in the bed room of Resident R63 in January, 2024. Employee E8 reported seeing Resident R44 was in the process of removing Resident R63 underwear (brief), while the resident was supine in bed. Further interview with Employee E8 revealed that Resident R44 was escorted to the dining room on the third floor nursing unit away from Resident R63. Employee E8 also reported that Resident R44 was fully clothed upon entering the bed room. Interview with nurse aide, Employee 8, at 10:30 a.m., on March 26, 2025 revealed that this employee reported the incident of nonconsensual touching to a licensed nurse on the unit and to the unit manager. Review of Resident R63 and Resident R44's January 2025 nursing documentation revealed no documented evidence of the above observation reported by nurse aide, Employee E8. Interview with administrative staff Employees E1 and E2 at 11:00 a.m., on March 26, 2025 confirmed that there was no documentation at the facility of any report related the Resident R44 being observed removing Resident R63's brief. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with nursing aide, Employee E9 at 9:30 a.m., on March 26, 2025 revealed that this employee was familiar with the care of Resident R44. The nursing aide, Employee E9 described Resident R44 as being independently ambulatory throughout the facility and that it was common knowledge of Resident R44 to ambulate away from the third floor nursing unit, unsupervised and down to the vending machine for snack foods. Interview with registered nurse, Employee E25 at 2:30 p.m., on March 26, 2025 confirmed that this nurse was responsible for supervising Resident R44 during the 3-11 tour of duty on the third floor nursing unit. The registered nurse reported that Resident R44 likes to verbally curse profanity toward the male residents. The registered nurse said that Resident R44 was independently ambulatory and would walk into other residents (male and female) rooms unsupervised taking their clothing. The registered nurse also reported that Resident R44 would expose himself and urinate in the hallway or lounge area during the 7-11 nursing shift. A review of the clinical record and care plan for Resident R44 revealed that there was incomplete and unavailable documentation to indicate that staff were monitoring this resident's whereabouts, since January, 2024. There was no documentation to indicate that 15 minute, 30 minutes, or hourly checks were complete and accurately documented by staff for this resident since January, 2024. The facility documentation of monitoring of Resident R44's whereabouts was confirmed with the Director of Nursing at 10:15 a.m., on March 26, 2025. A review of the nursing staff assignment sheets for March 24 and March 25, 2025 revealed that nursing staff were not explicitly assigned duties to supervise the care of Resident R44. The nursing assignments for March 24, 2025 and March 25, 2025 were confirmed with Licensed nurse, Employee E24, on March 26, 2025 at 9:00 a.m. 28 Pa. Code 201.14(b) Responsibility of licensee 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1) Nursing services 28 Pa. Code 211.5(f)(ii)(iii)(ix) Medical records

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on a review of clinical records, observations, and staff interviews, it was determined that the facility failed to identify the placement of beds against the wall as a restraint, the use of a seatbelt on a wheelchair as a restraint, and did not assess the functional status of an individual resident to determine the appropriateness of using a restraint for two of the 26 residents reviewed (Resident R108 and Resident R26) Findings Include: Review of Resident R108's clinical record revealed that the resident was admitted to the facility February 1, 2024, with a diagnosis of difficulty in walking, and encephalopathy (disease that affects the brain's structure or function). On March 24, 2025, at 12:52 p.m., Resident R108 was observed sitting in a wheelchair in the dining room with a seatbelt fastened across his waist. The seatbelt was locked, preventing the resident from being able to release it. This observation was confirmed by the unit manager, Employee 19, who reported that Resident R108 does not have an order for the use of a seatbelt restraint and expressed uncertainty as to why the seatbelt was locked across his knees. Clinical record review revealed Resident R26 was admitted to the facility November 06, 2020 with a diagnosis of diabetes mellitus (condition of high blood sugar caused by insulin problems), morbid obesity, and difficulty walking. Observation on March 24, 2025 at 10:05 a.m. revealed Resident R26's left side of bed was against the wall. Interview with Resident R26 on March 24, 2025 at 10:06 a.m. revealed Resident R26's bed against the wall is not preference based and the bed was against the wall when resident was moved into the room. Further interview with Resident R26 revealed his bed against the wall prevents him from getting out of bed on the left side. Review of Resident R26's clinical record revealed no physician assessment for Resident R26's bed against the wall and no care plan related to the purpose of Resident R26's bed against the wall. Interview on March 18, 2025 at 9:30 a.m. with Unit Manager, Employee E24, revealed Resident R26 has a larger bed due to residents size and Resident R26's bed may be against the wall due to limited space. 28 Pa. Code 211.8(e)(f) Use of Restraints. 28 Pa. Code:211.12(d)(1)(5) Nursing services.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on reviews of personnel files and the Department of State documents, staff interviews and reviews of policies and procedures, it was determined that the facility failed to perform criminal history background checks for two of two volunteer files (Employees E10, and E11) reviewed and the facility failed to ensure residents were protected from abuse by implementing the established abuse policy (Residents R63 and R44). Findings include: A review of the undated facility policy titled resident rights, abuse, neglect, mistreatment or misappropriation of resident property revealed that it was the responsibility of the facility to prevent abuse, neglect, mistreatment or misappropriation of resident property. The policy indicated that all staff were responsible for reporting and investigating abuse including resident to resident abuse. The policy indicated that all employees would be screened for convictions of abuse. The nurse aide registry, licensing authorities and references would be referenced for each employee prior to hire. Residents would be screened by the social worker for personal or family history of abuse. The policy indicated that all employees, including management staff and volunteers would receive training upon orientation and annually about recognizing, reporting and prevention of abuse. The training was to include how staff was to report their knowledgement of allegations of abuse without fear of reprisal. All residents and families and staff were encouraged to report concerns of abuse without fear of retribution. The facility administration was responsible to provide feedback regarding the concern that was expressed. All staff and volunteers would be trained to immediately report an observed/suspected incident of abuse. The facility had a zero tolerance for resident abuse, neglect, mistreatment or misappropriation of resident property by anyone including staff members, other residents, consultants, volunteers, and staff of other agencies serving the residents. Any witness to abuse must submit a report immediately to the employee's supervisor. The witness must report to the nursing supervisor the following information: name of the resident involved, date and time of the incident, location of the incident, the perpetrator, names of other witnesses to the incident, type of abuse. The nursing supervisor was then responsible for examining the resident. The nursing supervisor was responsible for recording the incident of abuse or alleged abuse in the residents' clinical record. The policy indicated that the nursing supervisor was to notify the abuse coordinator (the nursing home administrator and Director of nursing). During the investigation the perpetrator will be supervised or suspended, pending the results of the investigation. An incident report (documentation) would be completed for the abuse event and the physician would examine the resident as indicated. The abuse coordinator would be responsible for complete a comprehensive investigation of the alleged abuse. The investigation would be recorded and reported to State Agencies as required with corrective actions taken. The abuse coordinator would contact the resident or responsible party with the results of the abuse investigation report and corrective actions taken. On March 26, 2025, at 2:04 p.m. an interview with Volunteer Pastor, Employee 10 revealed that he and his wife, Employee E11 had been coming to the facility for 22 years to conduct religious activities. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 28, 2025, at 1:15 p.m. an interview with the Human Services Director, Employee E12 revealed that she was not responsible for conducting the State Police background checks. An interview was conducted with the Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2 on March 28, 2025, at 1:30 p.m. confirmed that criminal record for Volunteer Pastor, Employee 10 and his wife, Employee E11 were not conducted or available for review. Review of Resident R44's Minimum Data Set (MDS- a federal mandated assessment for all residents) dated December 25, 2024, revealed Resident R44 was admitted into the facility June 2, 2023, with diagnoses of bipolar disorder (condition in which a person has periods of depression and periods of being extremely happy), human immunodeficiency virus and dysphasia (problem swallowing). Resident R44's cognition was evaluated as a BIMS (brief interview mental status) score of 10 indicating resident R44 has moderate cognitive impairment. This resident functional abilities are mainly independent with ADLs (activities of daily living). Review of psychology note dated February 21, 2024, revealed summary of session, which noted that Resident R44 admitted to physically assaulting a staff member. He displayed hypersexual thoughts and behaviors. The clinician informed unit nurse manager and voiced the concerns that he is fixated on having sex and has made comments about wanting to act when his urges. Interview with nursing aide, Employee E8 on March 24, 2025, at 10:15 a.m. revealed that this employee had witnessed Resident R44 taking off Resident R63's underwear. Resident R63 does not have the cognition to consent. Employee 8 stated that she went directly to the nurse unit manager and reported it last January. Employee E8 stated that Assistant Director of Nursing and Director of Nursing and Nursing Home Administrator were all made aware of the incident. Employee E8 stated that she is aware of two other occasions that Resident R44 was caught having inappropriate sexual behavior. Interview with the Nursing Home Administrator, Employee E1 and Director of Nursing, Employee E2 at 12:00 p.m., on March 26, 2025 revealed that both administrative staff members who were the facility's abuse coordinators, said that they were unaware of any reports of possible sexual abuse, for Resident R44. Continued interviews with the director of nursing and the administrator confirmed that they were unaware of any reports of inappropriate sexual conduct by Resident R44. 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 201.19(8) Personnel policies and procedures

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on review of clinical records and interview with staff, it was revealed that the facility did not ensure revisions were made to the PASRR (Pre-admission Screening and Resident Review) application to include mental health diagnoses for 3 out of 3 residents reviewed. (Resident R108, R10, R90). Findings include: Review of Resident R108's PASRR completed on January 31, 2024, indicated that Resident R108 had no mental health diagnosis. Review of R108's clinical record revealed on May 2, 2024, obtained a mental disorder and on April 4, 2024, obtained an anxiety disorder. A review of Resident R10's PASRR completed on February 24, 2023, indicated that Resident R10 had a mental health condition of Schizophrenia (serious mental health condition that affects how people think, feel, and behave) , altered mental status. A review of the resident diagnosis revealed that Resident R10 also had mood disorder due to known physiological condition as of July 24, 2023. Clinical record review revealed Resident R90 had a mental diagnosis of Bipolar Disorder (mental health condition that causes extreme mood swings), obtained October 11, 2024, and Schizophrenia obtained October 28, 2024. Review of Resident R90's PASRR completed on October 11, 2024 revealed Resident R90 had a mental diagnosis of Bipolar Disorder. Further review of Resident R90's clinical record revealed no updated PASRR to include Resident R90's diagnosis of Schizophrenia. Interview with the facility Social Worker, Employee E3 on March 26, 2025, at 02:05 p.m., confirmed that facility did not update any PASSAR forms for any residents if they were not a target for level 2. It was further confirmed that the PASSR forms for Residents R108, R10 and R90, should have been updated with the additional updated mental health diagnosis. 28 PA Code 211.10 (c) Resident Care Policies 28 PA Code 211.5(f)(viii) Medical records

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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** Based on review of facility policy, facility documentation, review of clinical records, and interview with staff; it was determined the facility failed to develop a comprehensive care plan and interventions to address Resident R30's recent overdose, Resident R36's lack of toiling program and Resident R69's past traumatic stress disorder (PTSD) abd self administration of medication (Resident R94) for 4 of 26 residents reviewed. (Resident R30, R36, R69, R94) Findings include: Review of facility policy titled Interdisciplinary Care Planning Protocol undated, revealed Nursing admission Assessment completed on day of admission but in no event later than 24 hours of admission. Nursing Initiates interim Care Plan-the interim care plan must address all immediate care needs. Review of Resident R30's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnosis of other low back pain, opioid dependency, and anxiety disorder. Review of Resident R30's quarterly Minimum Data Set assessment (MDS- assessment of resident care needs) dated March 20, 2025, revealed the resident had a BIMS (Brief Interview of Mental Status) score of 15, indicating the resident was cognitively intact. Clinical progress notes dated March 8, 2025 revealed that Resident R30 noted to be lethargic, Vital Signs (VS) obtained temperature (T)97.6, heart rate (HR) 74, R18, blood pressure (BP)130/90, oxygen (O2)96%. x 1 dose of norcan administered with positive response. Clinical progress notes dated March 7, 2025, revealed Resident R30 Leave of Absence (LOA) with granddaughter at 9:00 a.m. to get ID. Resident R30 returned from LOA (leave of absence) at 12:00 p.m. Review of Resident R30's care plan revealed that a care plan was initiated on December 12, 2024, for history of substance seeking behavior (alcohol, oxycodone and benzos, other and has potential for complications such as substance abuse, withdrawal symptoms, and mood and or behavioral disturbance. Intervention documented as administer medication as ordered and observe for effectiveness and/onside effect. And second intervention updated on March 24, 2025 observe mouth and hands after each medication administration to ensure resident swallowed pills. A progress note dated March 10, 2025 by the Physiatry, Employee E23 seen today at bedside nursing report of overdose over the weekend requiring Norcan with positive effect. She had been excessively drowsy and lethargic on Saturday morning, unable to arouse multiple times prior to Norcan administration. On review of medications, he facility prescribed regiment of oxycodone has been at a stable long term dose for her chronic neck pain and has not had issue with lethargy or drowsiness for the 3 months she had been here. She had previously displayed signs of med seeking higher doses which I determined were not indicated, as noted previously. We kept her current dose as she does have indicated for cervical surgical interventions which was delayed and reason for severe neck pain. Per nursing she did go out of the building with here granddaughter on Friday (the day prior to her Narcan administration) and do suspect she may have gotten illicit substance at that time. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of resident's care plan revealed that it was not until March 11, 2025, (3 days from the incident related to the administration of Narcan) that the resident's care plan was revised to address alcohol, narcotics, and other drug use, with potential complications such as recurrence of substance abuse, post-acute withdrawal symptoms, and mood or behavioral disturbances. The goal outlined in the plan was for the resident to exhibit acceptable behavior, as evidenced by: no alcohol or drugs hidden in the room or brought by visitors, and no use of addictive substances unless prescribed by a doctor. The interventions include administering medications as ordered and monitoring for side effects and effectiveness, particularly with Naloxone. On April 2, 2025, at 11:05 a.m., an interview with the Director of Nursing confirmed that the revised care plan does not include interventions to identify and monitor behavioral changes, or signs and symptoms that may indicate potential drug use upon returned from LOA. Additionally, it was noted that ongoing consent from the resident to search their belongings upon returning from a LOA has not been addressed. Clinical record review for Resident R36 revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated March 4, 2025 that this resident was moderately cognitively impaired. The assessment indicated that this resident was incontinent of bowel and bladder. The assessment also said that this resident required substantial assistance with staff for transfers from the bed to the toilet or bed pan. The assessment indicated that the resident was dependent on staff for toileting hygiene. Interview with the nursing assistant, Employee E26, at 10:00 a.m., on March 28, 2025 revealed that this nursing assistant was assigned to the care of Resident R36. The nursing assistant reported that Resident R36 did not have an individualized care plan for toileting. The nursing assistant said that Resident R36 uses an incontinent brief for bowel and bladder episodes. The nursing assistance's experience with caring for Resident R36 was that the resident will use the call bell to let staff know he needs staff assistance to be changed after voiding or a bowel movement. Clinical record review confirmed that Resident R36 did not have a care plan developed for prompted toileting (upon rising, before and after meals and at bedtime). There was no documented evidence that toileting equipment (bed pan, bed side commode) had been trialed with Resident R36. There was no evidence that resident care equipment (mechanical lift) was being used for Resident R36's toileting needs. Clinical record review for Resident R94 revealed a quarterly MDS assessment dated [DATE] indicated this resident was cognitively intact and had no swallowing problems with foods or fluids. The assessment also indicated that the resident had adequate vision, was able to follow directions and had no functional limitations of upper extremities. Interview with Resident R94 at 2:30 p.m., on March 24, 2025 revealed that the resident does order medications (airborne gummies, Centrum silver, finasteride, folic acid, glipizide, glycolax powder, docusate sodium, ascorbic acid, ferrous sulfate) to be delivered to the facility or that the facility pharmacy delivers to the facility for him. Resident R94 reported that he was a retired pharmacist and he was interested in administering medications to himself. The resident was understanding that he would have to be provided with a locked bed side cabinet to secure the medications from staff and other residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inteview with the licensed practical nurse, Employee E24 at 2:40 p.m., on March 24, 2025 reported being aware that the resident had been requesting to self administer medications, since admission to the facility on December 13, 2024. The licensed practical nurse, Employee E24 verified that there was no care plan developed for Resident R94 to self administer medications as desired. 28 Pa. Code 201.18(e)(1) Management 28 Pa Code 211.10(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1) 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. Based on resident and staff interview, review of facility policy and staff interview, it was determined that the facility failed to properly supervise residents during medication administration for one of 26 residents reviewed (Resident R57). Findings include: Review of Facilities' policy titled Administering medications reviewed January 18, 2025 revealed under section Policy Interpretations and Implementation stated only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. Never leave a medication unattended in a resident's room. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. Review of Resident R57's clinical record revealed that the resident was admitted to the facility August 9, 2019 with a diagnosis of Traumatic Brain Injury, Hypokalemia (low potassium), and Hypertension (high blood pressure), Depression and Anxiety. Review of Resident R57's clinical record revealed no documented evidence that order was in place for Resident R57 to self-administer medications. Review of Resident R57's comprehensive care plan initiated on November 28, 2022, revealed that resident barricades in bathroom and room entrance door and is at risk for harming self and others. Review of Resident R57's Minimum Data Set (MDS assessment of resident care needs) dated March 18, 2025, in Section C- Cognitive Patterns revealed that resident has a BIMS (brief interview for mental status) of 13, which indicated that the resident was cognitively intact. Interview with Resident R57 on March 24, 2025 at 11:50 p.m. revealed that resident had concerns about receiving medications on time and stated 3 months ago, I did not receive my medications for 2 or 3 days and I got dizzy because I wasn't getting my meds. So I take them on my own now, I save them in my drawer so when they miss my medications, I can take it myself. Observation on March 24, 2025 at 11:52 PM, revealed Resident R57 removing a clear tupperware-like container with a blue lid from her bedside table and showing the container filled with multiple types of pills and 1 paper medication cup inside. Continued interview with Resident R57 on March 24, 2025 at 11:52PM revealed that she had taken her meds this morning because this is a good nurse, she knows how to give me my meds, a lot of them don't know and just forget about me. Interview with Unit Manager, Employee E19, on March 24, 2025 at 11:53PM, confirmed multiple pills and 1 paper medication cup being stored in Resident R57's bedside table in clear Tupperware-like container with blue lid. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Unit Manager, Employee E19 on March 24, 2025 at 11:53PM, employee removed paper medication cup from clear container and dumping numerous multicolored pills onto a clean white napkin. Observation on March 24, 2025 at 11:54PM, revealed Unit Manager, Employee E19 escorted pills to the medication cart of Registered Nurse, Employee E21 and were place on top. Observation on March 24, 2025 at 12:05 PM, revealed Registered Nurse, Employee E21 counting and identifying pills as follows, Hydrochlorothiazide 25mg- 35 pills counted, Amlodipine 5mg - 13 pills counted, Potassium Chloride 20 meq- 4 pills counted (split in half). Continued observation revealed pills appear dry, no visible deterioration or discoloration, white napkin remained dry and no visible signs of discoloration. Upon transfer of pills to the top of the medication cart, visible dust and residue remained from pills. Observation on March 24, 2025 at 12:05 PM, revealed medication counted and confirmed by Unit Manager, Employee E19 and Registered Nurse, Employee E21 revealed a total of 52 pills discovered in Resident R57's bedside table. Review of Resident R57's Clinical record revealed a physician order dated November 8, 2023, for Hydrochlorothiazide 25 milligrams (mg) by mouth one time a date related to hypertension hold for a systolic blood pressure <100 or a HR (heart rate) <55. Further review of Resident R57's clinical record revealed a physician order dated October 19, 2023, for Amlodipine besylate 5 mg by mouth in the evening related to hypertension, hold for a systolic blood pressure <100 or a HR <55. Continued review of Resident R57's clinical record revealed a physician order dated December 21, 2022, for Potassium Chloride ER (extended released) 20 meq by mouth daily. 28 Pa. Code 201.18(e)(1) Management 28 Pa Code 211.10(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1) Nursing Services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, clinical record review, interview with staff and review of policies, it was determined that the facility failed to ensure that a resident was provided with devices to optimize posture during dining and failed to collect additional nutritional biochemical data related to the resident's nutritional status for one of five residents reviewed. (Resident R63) Findings include: A review of the undated policy titled nutrition evaluation indicated that it was the facility's responsibility to ensure that each resident received proper nutrition and dietary support to promote their health and well being. The policy also indicated that each resident would undergo a nutritoinal assessment by a registered dietitian. The dietitian was responsible for assessing the resident's medical history, dietary preferences, allergies and and special dietary needs. The dietitian would also be responsible for assessing biochemical data collected related to a resident's nutritional status. The facility would collaborate the healthcare professionals (physician, nursing, dietitian occupational therapist speech/swallowing pathologist) to ensure that each resident's nutritional needs are effectively met. Clinical record review revealed a quarterly assessment Minimum Data set (MDS- an assessment of care needs) dated January 1, 2025 for Resident R63 that indicated this resident was severely cognitive impaired. The assessment indicated the resident was prescribed a mechanically altered diet and that the resident required substantial assistance of staff with eating. Observations of Resident R63 during the noon meal service on the third floor nursing unit on March 24, 2025 revealed that this resident was sitting in the dining room, in her wheel chair, being assisted with her meal by the nursing staff. The resident's head was tilted to the side and chin positioned in her chest. The nursing staff said that Resident R63 had not been evaluated for adapted equipment to ensure upright positioning during meals and safe swallowing. Interview with the occupational therapist, Employee E32 at 11:30 a.m., on March 26, 2025 revealed that it was not until March 26, 2025 that Resident R63 was assessed and supplied with a high back wheel chair for postural alignment of her back and neck. Clinical record review for Resident R63 revealed that this resident was prescribed Levothyroxine 25mcg one time a day for low production of thyroid hormone in the body or hypothyroidism, since December 29, 2024. Review of Resident R53's clinical record revealed the the resident had a diagnosis of hypothyroidism (the thyroid gland does not produce enough thyroid hormone). The only biochemical data available for review for Resident R63 was dated August 30, 2024 that indicated a low thyroid stimulating hormone of .17uIU/ml with a normal range of .3 to 4.2, free T4 that was within normal range and no T3 available for review. A low TSH (thyroid stimulating hormone) laboratory value was indicative of probable hyperthyroidism (over production of thyroid hormone in the body). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the licensed practical nurse, Employee E24, at 11:00 a.m., on March 26, 2025 confirmed that there were no other nutritional related biochemical studies for Resident R63 available for review. 28 Pa. Code 211.10(a)(b)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 201.14(a) Responsibility of licensee

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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** Based on clinical record review, review of facility policy and staff interview, it was determined the facility failed to provide respiratory care consistent with professional standards of practice for one of one resident reviewed (Resident R23). Findings include: Review of facility policy titled Oxygen Therapy, no date, revealed Oxygen (02) is administered appropriately to residents to improve oxygenation and provide comfort to residents experiencing respiratory difficulties. Oxygen is administered by licensed staff with a physicians order. In an emergency oxygen can be administered and order should be received as soon as possible. Clinical record review revealed Resident R23 was re-admitted to the facility on [DATE] with a diagnosis of sepsis (serious condition in which the body has a severe response to an infection), chronic obstructive pulmonary disease (lung condition caused by damage to the airways that limit airflow), and hypertension (high blood pressure). Observation on March 24, 2025 at 11:28 a.m. revealed Resident R23 was receiving 2 Liters of oxygen. Further observation revealed Resident R23's oxygen tubing did not include a date of when the tube was connected. Review of Resident R23's clinical record revealed no physician order for oxygen to be administer. Interview on March 24, 2025 with Certified Nursing Assistant, Employee E14, confirmed Resident R23's oxygen tubing was note dated. Interview on March 24, 2025 at 11:51 a.m. with Registered Nurse, Employee E15, confirmed Resident R23 did not have an order for oxygen to be administered. 28 Pa. Code 211.12(d)(5) Nursing services

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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. Based on review of clinical records, staff and resident interviews, it was determined that the facility failed to provide culturally competent, trauma informed care in accordance with professional standards of practice, accounting for the resident's past experience and preferences in order to eliminate and /or mitigate triggers that may cause re-traumatization of the resident for one of four residents reviewed. (Resident R 69) Findings include: Review of facility policy titled Trama Informed Care,revealed the facility ensures that residents who are trauma survivors receive culturally competent, trauma informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Upon admission the facility will assess each resident to ensure they receive appropriate treatment and services. A questionnaire will be utilized for each resident by the social services department in order to identify any trauma and/or post-traumatic stress disorder and to gather trigger information so that our understanding of their traumatic events can be detailed and specific. Additional information may be obtained from the medical record, physical and emotional assessments, from the resident, from family members who have shared this information. The facility will provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing in accordance with the individual resident assessment and plan of care. The facility will ensure employees have education training or in-service in caring for residents identified with mental and psychological disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder. Care plans and interventions will be reviewed quarterly and more often, if necessary, based on any change in the residents physical and psychosocial well-being. As we evaluate our interventions, we will be sensitive to the need for professional referral to psychological/mental health services and personnel as well as ways to communicate our plans to staff in order to enlist their support. Review of Resident R69's annual Minimum Data Set (MDS-federal mandated assessment for all residents) dated February 1, 2025 revealed that the resident was admitted into the facility on August 24, 2021 with diagnoses of heart failure, hypertension (high blood pressure) and schizophrenia (a mental disorder characterized by hallucinations, delusions (disorganized thinking and behavior). Resident R69 has a BIMS (brief interview of mental status) of 9 indicating that Resident R69 was moderately cognitively impaired. Review of Resident R69's psychological note dated August 14, 2024, revealed patient admits that his anger gets him in trouble and sometimes physical altercations. He believes this is due to a real perceived sexual assault in the past he has said he is on edge and offensive and protective of himself and his body. Review of Residents R69's care plan revealed Resident R69 was admitted into a psychiatric hospital for behavior as a voluntary admit on January 14, 2025 due to aggressive behaviors towards staff members. (continued on next page)

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	395525	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy Hill Post Acute Nursing & Rehabilitation LLC	1401 Ivy Hill Road Philadelphia, PA 19150

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of psychiatric hospital discharge notes dated January 15, 2025 revealed that Resident R69 was referred to the hospital from the nursing facility with a diagnosis of psychosis triggered by PTSD (post-traumatic stress disorder) relating to past sexual trauma patient presenting with increased mania agitation and a history of trauma. Review of Resident R69's clinical record revealsed no indication that this resident has been assessed for PTSD, educated and or treated for this documented diagnosis of post-traumatic stress disorder. Interview with Director of Nursing, Employee E2 on March 27, 2025 confirmed that Resident R69 was diagnosed with PTSD and not care planned for it. 28 Pa. Code 211.12(c)(d)(3) Nursing Services 28 Pa. Code 211.11(e) Resident Care Plan 28 Pa. Code 211.16(a) Social Services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on a review of clinical record review, and interviews with staff, it was determined that the facility failed to ensure that medication regimens were followed by the facility in a timely manner for two of the five residents reviewed related to medication regimen reviews (Residents R30 and R61). Findings include: Review of Resident R30's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnosis with atherosclerotic heart diseases of native coronary artery without angina pectoris, and cerebral infarction (stroke). Continued review revealed that the resident received Atorvastatin Calcium Oral Table 80 milligrams give 1 tablet by mouth prescribed by the physician on December 13, 2024. A Pharmaceutical review of the Medication Regimen was conducted on December 23, 2024, and February 26, 2025 revealed a recommendation for Lipids suggested with 80 mg (milligrams) Atorvastatin. Review of Resident R30's clinical record revealed no documented evidience that a laboratory study for lipids was completed. An interview was held on March 28, 2025, at 1:38 p.m. with Employee E2, Director of Nursing (DON) who confirmed that the recommendation to perform Lipids labs was not followed on December 23, 2024, and on February 26, 2025. Review of Resident R61's clinical record revealed Resident R61 was admitted to the facility on [DATE] with a diagnosis of necrotizing fascitis (serious bacterial infection), amputation of right foot, and hypotension (low blood pressure). Further review of Resident R61's clinical record revealed a physician order, dated November 21, 2024, for Midodrine (medication to treat low blood pressure) 5 mg to be given 1 time a day every Tuesday, Thursday, and Saturday for hypotension during dialysis. Review of Resident R61's monthly pharmacy review, dated January 08, 2025, revealed a pharmacist recommendation for Midodrine order to include a blood pressure limit. Further review of Resident R61's January 2025 throguh March 2025 physician order for Midodrine revealed no blood pressure limit was included in the order. Interview on March 28, 2025 at 12:21 p.m. with Employee E2, DON, confirmed pharmacy recommendation was not followed. 28 Pa Code 211.9(f)(3) Pharmacy services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on the review of clinical records, and staff interviews, it was determined that the facility failed to ensure that as needed anti-anxiety medication was limited to 14 days unless a documented rationale was provided for one of eight residents reviewed for medication administration regimen. (Resident R69) Findings include: Review of physician orders for Resident R 69 dated March 25, 2025, revealed that there an order for Lorazepam (Ativan-this medication is used to treat anxiety) 1 mg, to give every twelve hours PRN (as needed) for agitation, end date is indefinite. Review of clinical record for Resident R 9 revealed no evidence that the attending prescribing practitioner documented the rationale for use as needed anti-anxiety medication in the resident's clinical record and indicated the duration for the prn order. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing Services

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on review of the clinical records, review of facility policies and interviews with staff, it was determined that the facility failed to ensure that a resident was free of significant medication error for one of four residents reviewed for medication administration relating to prescribed route of medication administration. (Resident R 116) Findings include: Review of facility policy titled Administering medications revised January 18, 2025, revealed that medications shall be administered in a safe and timely manner and in accordance with the physician order. The individual administering the medication must check the label to verify the right resident, for right medication, right dosage, right time, and rate route of administration before giving the medication. Review of Resident R116's quarterly Minimum Data Set (MDS- a federal mandated assessment tool for all residents) dated December 27, 2024 revealed that Resident R116 was admitted into the facility July 12, 2024 with diagnoses including renal failure (kidney failure) and traumatic brain injury. Resident R116 is on a therapeutic diet with the aid of a feeding tube. Review of Resident R116 physician orders revealed current orders for the medication Propranolol 20 milligrams (mg) to be given 1 tablet via peg-tube, the medication Lansoprazole 30 mg to be given via peg-tube, and multi vitamin to be given via peg-tube . Review of Resident R116's care plan revealed that Resident R 116 is at risk for alteration and hydration related to dysphasia (difficulty swallowing), fluid restriction, tube feeding with interventions to include administer medication per physician orders date-initiated July 26, 2024. Observation of medication pass on March 25, 2025, at 08:15a.m. on the second-floor nursing unit, east med cart with Licensed nurse, Employee E21, revealed that Employee E21 crushed the pills and administered the medications orally to Resident R116. Interview with Resident R116 at time of observation revealed that the resident usually is given medications orally. Interview with Licensed nurse, Employee E21 on March 28, 2025, at 11:59 a.m. revealed that she has always administered Resident R116's medication orally. This employee stated that she was told to during morning meeting. Interview with Director of Nursing, Employee E 2 on March 28, 2025 at 11:59 a.m. confirmed that the resident has current orders for medications to be administered via peg-tube. 28 Pa. Code 211.12(d)(1) Nursing Services 28 Pa. Code 211.12(d)(3) Nursing Services

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on personnel record review, and staff interview, it was determined that the facility failed to provide abuse, neglect and exploitation training for two of two volunteer staff reviewed (Employee E10, and E11). Findings: A review of the Facility Policy titled Residents/Patient Right-Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property undated, revelated All employees, including management staff and volunteers, will receive training upon orientation and annually. In-services regarding abuse, neglect, mistreatment or misappropriation of resident's/patient's property. Training will include how staff should report their knowledge of allegations without fear of reprisal; How to recognize signs of burnout, frustration and stress that may lead to abuse On March 26, 2025, at 2:04 p.m. an interview with Volunteer Pastor, Employee 10 revealed that he and his wife, Employee E11 had been coming to the facility for 22 years to conduct religious activities. On March 28, 2025, at 1:15 p.m. an interview with the Human Services Director, Employee E12 revealed that she is not responsible for conducting training for any volunteers. An interview was conducted with the Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2 on March 28, 2025, at 1:30 p.m. confirmed that abuse training for volunteer Pastor, Employee 10 and Employee E11 ere not conducted or available for review. 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 201.19(8) Personnel policies and procedures