

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER Aristacare at Meadow Springs		STREET ADDRESS, CITY, STATE, ZIP CODE 845 Germantown Pike Plymouth Meeting, PA 19462	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>46993</p> <p>Based on observations, review of clinical records and interview with staff, it was determined that the facility failed to ensure that pressure ulcer prevention measures were followed as ordered by the physician for one of one resident with pressure ulcer reviewed. (Resident R69)</p> <p>Findings include:</p> <p>Review of facility's policy 'Prevention of Pressure Ulcers,' indicates that when in bed, every attempt should be made to 'float heels' (keep heels off of the bed) by placing a pillow from knee to ankle or with other devices as recommended by therapist and prescribed by the physician.</p> <p>Review of Resident R69's clinical records revealed past medical history of cerebral infarction, anoxic brain damage, persistent vegetative state, anemia, long-term anticoagulant use, gastrostomy status, and ventilator status.</p> <p>Review of February 2024 physician orders revealed an order revised on February 8, 2023 to wear prealon boots to BLE (bilateral legs) at all times except for hygiene or skin checks. Continued review of physician orders revealed another order dated April 15, 2022 to off load heels with pillows while in bed as tolerated.</p> <p>Review of R69's care plan revealed R69 has a history of impaired skin integrity related to cognitive deficit, fragile skin, limited mobility and chronic disease process with interventions such as to follow facility protocols for treatment of injury.</p> <p>Review of 'wound evaluation and management summary' from March 28, 2024 revealed stage 3 pressure wound of the right heel full thickness, etiology - pressure; re-opening of stage 3. Recommendations to off-load wound; reposition per facility policy; float heels in bed.</p> <p>Review of progress notes by wound care nurse, Employee E35, dated March 27, 2024 at 2:57 pm revealed Resident noted with stage 3 reopened pressure ulcer of Right heel. Area measures 4cm x 3cm with depth of 0.1cm. 100% granulating tissue . No S/S (signs and symptoms) of infection noted . Dependent on staff for bed mobility and repositioning. Resident has severe contractures of B/L lower extremities. ON FMP program for Prom and offloading of wedges and pillows between knees. Feet was not off loaded or prealon boots on resident@ time of discovery.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of progress notes dated April 11, 2024 at 9:07 am revealed no improvement noted to stage 3 right heel wound. Continue with current treatment as ordered.</p> <p>Another progress note dated April 12, 2024 at 9:53 am revealed R69 was seen by nurse practitioner, employee E37 for stage 3 pressure ulcer - the wound is improving slowly. Currently, her booties are not on.</p> <p>Interview with wound care nurse, Employee E35 on April 17, 2024 at 12:50 p.m. during observation of wound care treatment, revealed that right heel wound re-opened because sometimes heel boot is not on and sometimes pillow is not propped up under knee.</p> <p>28 Pa Code 211.10 (c) Resident care policies</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12 (d)(5) Nursing services</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47975</p> <p>Based on observation, review of facility policies, facility documentation and interviews with staff, it was determined that the facility failed to ensure that water temperatures in resident bathroom hand sinks and showers were maintained at a safe temperature for two of two nursing units observed (Unit One and Unit Two). This failure placed residents on Unit One and Unit Two at risk for serious injury from a burn and resulted in an Immediate Jeopardy situation.</p> <p>Findings Include:</p> <p>Review of the Water Temperatures, Safety of Policy undated states that tap water . shall be kept within a temperature range to prevent scalding residents.</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 100 degrees (44.33 Celsius), or the maximum allowable temperature per state regulation. 2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log. 3. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in the safety log. 4. If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor. 5. Direct-care staff shall be informed of risk factors for scalding/burns that are more common in the elderly, such as: <ol style="list-style-type: none"> a. Decreased skin thickness b. Decreased skin sensitivity c. Peripheral neuropathy d. Reduced reaction time e. Decreased cognition f. Decreased mobility g. Decreased communication <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>6. The length of exposure to water or hot water, the amount of skin exposed, and the resident's current condition affect whether or not exposure to certain temperatures will cause scalding or burns. Therefore, ongoing resident observation and assessment during prolonged exposure to warm or hot water will help determine the safety of the situation.</p> <p>7. Nursing staff will be educated about signs and symptoms of burns (first, second, and third degree) so that such injuries can be recognized and treated appropriately.</p> <p>Review of the Facility Shower/Bath Policy dated April 2023 stated that the purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.</p> <p>General Guidelines</p> <p>1. Be sure that the bath area is at a comfortable temperature for the resident.</p> <p>Equipment and Supplies</p> <p>10. Fill the tub approximately one-half (1/2) full with water (105 F [40.5 C]). Test the water with the bath thermometer or your elbow. If using a shower regulate the temperature and the flow of the water.</p> <p>skin for any rashes, reddened areas, skin discoloration, etc.)</p> <p>Observation of the shower room one on Unit One on April 16, 2024, at 11:30 a.m. revealed nurse aide, Employee E10 was preparing the shower for a resident. Employee E10 was asked how she takes the temperature of the water? Employee E10 replied that the particular shower took a while to heat up and she test the temperature of the water on her hand or on her wrist. Observation of the shower room revealed there was no thermometer located in the room.</p> <p>Further observation of shower room two on Unit One was at 11:34 a.m. revealed there was no thermometer located in the room. The hot water at the hand sink in the shower room was turned on and felt too hot to the touch. Hot water temperatures were taken of the shower and the hand sink with he Director of Maintenance, Employee E12 on April 16, 2024, at 11:36 a.m. The hot water temperature at the sink was 124 degrees Fahrenheit. The shower temperature was 112 degrees Fahrenheit. The Director of Maintenance confirmed that the temperature of the hot water was high and that it should be between 98 degrees Fahrenheit and 110 degrees Fahrenheit.</p> <p>Observation of the shower room on Unit Two on April 16, 2024, at 11:40 a.m. with the Director of Maintenance Employee E12 revealed that there was no thermometer located in the shower room. Hot water temperatures were taken of the shower as well as the hand sink at 11:41 a.m. The hand sink temperature was 122 degrees Fahrenheit and the shower temperature was 114 degrees Fahrenheit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Observation of the boiler room on April 16, 2024, at 11:45 a.m. with the Director of Maintenance, Employee E12 revealed a domestic water storage tank which had a leak and water was observed on the floor. The Director of Maintenance, Employee E12 stated that the leak started over the week and that they currently had someone on site to drain the water and fix the tank. Observation was made of boiler one which was set at 118 degrees Fahrenheit. Observation was made of the incoming water tank which was set at 95 degrees. Interview with the Director of Maintenance, Employee E12 revealed the incoming water was high as it usually was set around 80 degrees Fahrenheit.</p> <p>A re-check of the water was completed on the shower room two on Unit One with the Director of Quality Experience, Employee E11 on April 16, 2024, at 12:19 p.m. The hand sink temperature was 117 degrees Fahrenheit.</p> <p>Observations conducted of the hand sink in resident rooms on Unit Two were as follows:</p> <p>room [ROOM NUMBER]- 112 degrees Fahrenheit</p> <p>room [ROOM NUMBER] -115 degrees Fahrenheit</p> <p>room [ROOM NUMBER] -112 degrees Fahrenheit</p> <p>room [ROOM NUMBER] -112 degrees Fahrenheit</p> <p>A re-check of shower room one on Unit One was completed on April 16, 2024, at 12:35 a.m. with the Director of Quality Experience, Employee E11. The temperature of the hand sink was 112 degrees Fahrenheit. Temperatures were taken of hand sinks in residents room at 12:38 p.m. were as follows:</p> <p>room [ROOM NUMBER] - 120 degrees Fahrenheit</p> <p>room [ROOM NUMBER] - 119 degrees Fahrenheit</p> <p>room [ROOM NUMBER] - 120 degrees Fahrenheit.</p> <p>room [ROOM NUMBER] - 124 degrees Fahrenheit.</p> <p>Review of the water temperature logs were completed for the month of April 2024. There was no documented temperatures during the weekends. Review of the water temperature logs revealed there was no temperatures recorded on the following dates: April 2, 2024, April 3, 2024, April 4, 2024, April 8, 2024, and April 9, 2024.</p> <p>Interview held with Licensed nurse, Employee E5 on April 16, 2024, at 1:38 p.m. revealed residents were given showers and bed baths on the unit on April 16, 2024. Licensed nurse Employee E5 stated he did not know what the hot water temperature should be for showers and he did not know of a thermometer being available in the shower room on the unit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview held with Nurse aide, Employee E40 on April 16, 2024, at 1:36 p.m. stated that the resident in room [ROOM NUMBER]D was given a shower. When asked did you test the temperature of the water? Nurse aide, Employee E40 stated yes with his hand. When asked if there was a thermometer available to test the water temperature, he stated no. When asked if he knew what the maximum temperature of the water should be he stated four.</p> <p>Interview held with Nurse aide, Employee E41 April 16, 2024 at 1:40 p.m. stated that she tested the hot water temperature with her hand. When asked did you have a thermometer available, she stated no there was not.</p> <p>Interview held with Nurse aide, Employee E42 one April 16, 2024, at 1:58 p.m. revealed that the resident in room [ROOM NUMBER]W was given a bed bath. When asked how you test the temperature of the water, she stated she tested it with her hand. When asked did you have a thermometer available, she stated no.</p> <p>Interview held on April 16, 2024, at 2:04 p.m. with Nurse aide, Employee E16 who was assigned residents in room [ROOM NUMBER]-D and 148-W. When asked if either residents were given a shower, Nurse aide, Employee E16 stated only resident on room [ROOM NUMBER]D was given a shower. When asked how do you test the temperature of the water, he stated he testes the water temperature on his hand and arm to see if it's too hot and also asks the resident. When asked did you have a thermometer available to test the temperature of the water he stated, no I have not had a thermometer available to test the temperature of the water. When asked what the temperature should be, he stated he does not know what the temperature should be.</p> <p>Interview held with Nurse aide, Employee E10 on April 16, 2024, at 1:49 p.m. revealed she was assisting giving the resident from room [ROOM NUMBER]B a shower. Nurse aide, Employee E10 stated she tests the water temperature with her hand and then takes the residents hand and has them test it to see if it is too warm. When asked what the temperature should be she stated lukewarm or warm. Nurse aide, Employee E10 also stated the water doesn't get hot due to safety. When asked what the highest temperature the water should be, she stated she does not know what degrees. When asked if there a thermometer available to test the water temperature in the shower room she stated that there was none available on the unit.</p> <p>Interview held with nurse aide, Employee E43 on April 16, 2024 at 2:03 p.m. revealed she use the thermometer in the shower room to test the hot water. When asked do you record the temperatures, she stated yes there should be a log sheet in the shower room.</p> <p>Interview held with Nurse aide, Employee E28 on April 16, 2024, at 1:51 p.m. revealed the resident in room [ROOM NUMBER] D was given a shower today. When asked how he tested the temperature of the water he said on my hand. When asked did you have a thermometer available, he stated no. When asked what the temperature was or did you record it he stated he doesn't know but it wasn't too hot, it's a set temperature throughout the facility. When asked what the temperature should be during a shower or a bed bath, he stated he does not know off the top of his head.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Based on the above findings Immediate Jeopardy to the safety of the residents was identified to the Nursing Home Administrator and the Director of Nursing (DON) on April 16, 2024, at 3:43 p.m. for failure to ensure that safe hot water temperatures were maintained on the First and Second Floor Nursing units. The Nursing Home Administrator was provided with the Immediate Jeopardy template and an immediate action plan was requested.</p> <p>On April 16, 2024 at 7:49 p.m. the facility developed and submitted the following Corrective Action Plan:</p> <ul style="list-style-type: none"> -The facility immediately suspended showers. -The maintenance supervisor adjusted the mixing valve and began monitoring. -Any residents who received a shower today has been assessed by nursing staff to ensure no injuries have occurred. -The facility mechanical contractors were on site and completed repairs to the hot water holding tanks. -The facility water policy on water temperatures and showering/bathing has been updated too include staff ensuring the water temperature is within acceptable range and to not give shower/bath. -Staff were immediately educated includes teaching staff how to properly test the water prior to giving the shower, and notify maintenance when temps are above the 110 requirement. -Thermometers have been placed in each shower room. - Staff in servicing has begun and will continue until all nursing staff have been educated. The staff will be in serviced prior to their next shift either in person or over the phone. The facility will be at 100% by 4/16/24 via text/email. Our system tracks individual signs offs of the notifications, followed by an in person/phone in-service prior to their next shift. - The facility will continue random temperatures monitors every shift through nursing supervisor, the maintenance supervisor will also complete temperature logs daily in the AM and again at the maintenance shift 5:00. - If the Maintenance director cannot be reached the Administrator will be notified if temperatures are found over 110. -Both logs will be summarized and reported to QAPI (Quality Assurance Program Improvement), with any trends and effective interventions monthly. <p>The facilities action plan was submitted and accepted on April 16, 2024 at 8:32 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Staff interviews were conducted on April 17, 2024 between 1:00 p.m. and 6:00 p.m., with nursing staff to verify the implementation of the immediate action plan. Nursing staff were able to verbalize to facility's updated policy, including that water temperatures should not exceed 110 degrees Fahrenheit, what to do if water temperatures were found to be too hot, and how often to check water temperatures. Nursing staff were able to demonstrate proper use of a thermometer for checking water temperatures and that they had sufficient thermometers available for use.</p> <p>Maintenance and Supervisory staff were observed checking water temperatures and completing audit logs. The hot water at residents' hand sinks were tested and verified that they did not exceed 110 degrees Fahrenheit. Water temperature logs were reviewed and revealed appropriate water temperatures. Staff education documentation was reviewed and revealed that the facility in-serviced 100 percent of the facility staff on proper hot water temperatures.</p> <p>Following verification of the implementation of the immediate action plan, review of water temperature logs and review of staff education documentation, the Immediate Jeopardy was lifted on April 17, 2024, at 5:49 p. m.</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p> <p>28 Pa Code 201.18(a) Management</p> <p>28 Pa Code 201.18(b)(1) Management</p> <p>28 Pa Code 201.18(b)(3) Management</p> <p>28 Pa Code 205.63(c) Plumbing and piping systems required for existing and new construction</p> <p>28 Pa Code 211.12(d)(3) Nursing services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>47975</p> <p>Based on review of facility policy, observations, record review, and staff interviews, it was determined that the facility failed to provide respiratory care services consistent with professional standards of practice for three of 34 residents reviewed. (Residents R38, Resident R41, Resident R390).</p> <p>Findings Include:</p> <p>Review of facility policy Disposable Equipment Changes undated states, Policy Statement- Respiratory care disposable equipment changes are consistent with manufacturer's recommendations, CDC guidelines and per Respiratory Care Clinical Practice Guidelines.</p> <p>Purpose-To establish guidelines for consistent changes of disposable equipment. To limit the occurrence of equipment related infection. To assure disposable equipment maintains both its physical integrity and proper function.</p> <p>Please note: All equipment (disposable/Non-disposable) including: nasal cannulas, aerosol tubing, nebulizer caps and tubing, treatment nebs, BIPAP/CPAP tubing and masks, must be stored in a clean set-up bad when not in use (between usage).</p> <p>Review of facility policy titled Tracheostomy Care undated states, Purpose: To establish standards for the care and maintenance of tracheostomy tubes. Following these standards will assist in maintaining a patent airway, reduce the risk for nosocomial infection, and help to prevent excoriation, breakdown, and infection of surrounding skin.</p> <p>Procedure:</p> <p>1. One sterile tracheostomy tube and obturator is kept at the patient's bedside for emergency use. (same size or one size smaller)</p> <p>Review of Resident R38's clinical record revealed the resident was admitted to facility on November 23, 2022 with a diagnosis of Acute and Chronic Respiratory Failure with Hypoxia, and encounter for attention to Tracheostomy.</p> <p>During an initial tour of the facility on April 16, 2024 at 11:03 a.m. it was observed that Resident R38 did not have an ambu bag and emergency kit set up at bedside.</p> <p>Further observation of unit one revealed that Resident R41 and Resident R390 had an ambu bag open to air set on top of equipment along the wall at the head of the bed.</p> <p>On April 16, 2024 at 11:57 a.m. and interview was held with Clinical Coordinator, Employee E27 confirmed there was no ambu bag and emergency kit set up at bedside for Resident R38. Employee E27 also confirmed the ambu bags not being in clean set-up bag and stated she would have to find some that would fit the equipment.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further observation on April 16, 2024 at 10:31 a.m. of Resident R85 aerosol tubing revealed there was no dated on the tubing. Interview with Respiratory Therapist Employee E9 at 11:20 a.m. confirmed the tubing should be changed monthly or as needed and confirmed Resident E85 did not have labeling on the filter of the tubing.</p> <p>28 Pa. Code 211.12(d)(1)(2) Nursing Services</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>47975</p> <p>Based on observation, review of facility documentation and interviews with staff, it was determined that the Nursing Home Administrator and the Director of Nursing failed to effectively manage the facility related to hot water temperatures which resulted in Immediate Jeopardy situation.</p> <p>Findings include:</p> <p>Review of the job description of the Nursing Home Administrator (NHA) revealed that, The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to our residents at all times.</p> <p>The job description of the Director of Nursing (DON) revealed that, The primary purpose of your job position is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be director by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times.</p> <p>Observations during initial tour of the facility on April 16, 2024, revealed that water temperatures in resident bathroom sinks and shower rooms were above 110 degrees Fahrenheit on both nursing units (Nursing Units One and Two). Observations and interviews with the Director of Maintenance on April 16, 2024, confirmed that water temperatures were greater than 110 degrees Fahrenheit and there was a failure to identify this prior to the initial tour. This failure placed residents at risk for serious injury from a burn and resulted in an Immediate Jeopardy situation.</p> <p>Based on the deficiencies identified in this report the NHA and DON failed to fulfill essential duties and responsibilities of their position, contributing to the Immediate Jeopardy situations.</p> <p>Refer to F689</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(a) Management</p>

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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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46993</p> <p>Based on review of clinical records, it was determined that the facility failed to ensure that residents records were accurately documented for one of 27 residents reviewed (Resident R69)</p> <p>Findings include:</p> <p>Review of Resident R69's clinical records revealed that the resident was [AGE] year old female with past medical history of cerebral infarction, anoxic brain damage, persistent vegetative state, anemia, long-term anticoagulant use, gastrostomy status, and ventilator status. Resident R69's physician is Employee, E38. The resident was admitted on [DATE].</p> <p>Review of R69's progress notes revealed a pulmonary progress note dated March 14, 2024 at 6:30 pm, completed by physician, Employee E39, which was not the resident's physician. The progress notes stated seen and examined 3/14/24 [AGE] year old male admitted in December after falling from bed. Found to have C4-5 fracture and underwent surgery as listed below. He put placed back on the vent due to pneumonia . Interval Recommendation - 2/16/24 Continue vent support on SIMV/PS. Continue weaning and advancing as tolerated. Hopefully can get back to trach collar during he day. Pulmonary toileting Daliresp 500 mcg Recommend Duoneb qid (every day) Recommend Budesonide 0.5mg neb BID (twice a day) Please obtain copy of prior CT chest to provide recommendations for follow-up of lung nodule. Hospital records reviewed. Interval Recommendation 3/7/24 He has been readmitted from the hospital. He was admitted with cardiac arrest.Continue vent support on SIMV/PS. He did PS as well today. Pulmonary toileting. Discussed with respiratory. Interval Recommendation 3/14/24 Continue vent support. On AC/14/440/35/5. Wean as tolerated.</p> <p>Findings confirmed with Nursing Home Administrator and Director of Nursing that the physician progress note was erroneously entered on Resident 69's clinical record and was not related to this resident.</p> <p>28 Pa Code 211.5(f)(ii)(iv) Medical records</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12(c) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343</p> <p>Based on facility policy and clinical record review, observations, and staff interviews, it was determined that the facility failed to maintain an effective infection control and prevention practice during medication administration for two of 27 residents reviewed. (Resident R6 and Resident R90)</p> <p>Findings include:</p> <p>Review of facility's policy title Administering Medications, revealed that medications shall be administered in safe and timely manner and as prescribed. No medications are kept on top of the cart.</p> <p>During observation of medication administration with Licensed nurse, Employee E36, on April 17, 2024 at 9:37 a.m. revealed an un-capped and pre-filled insulin syringe on top of cart. Employee E36 was observed carrying the un-capped insulin syringe to Resident R69's room and place it on bed side table.</p> <p>Employee E36 was observed to attempt to open new Lacosamide oral solution 10mg/ml bottle with her keys.</p> <p>Further observations revealed Employee E36 attempting to collect urine from Resident R69's foley by placing a cup under the urinary foley catheter, unable to uncap foley catheter. Employee E36 had her personal cell-phone fall on the floor multiple times - knocking the cup over, picking up phone from floor and touching the cup and foley catheter multiple times until nurse aide assisted in uncapping foley.</p> <p>A review of Resident R90's clinical record revealed that the resident was admitted to the facility on [DATE], with a diagnosis including Traumatic Hemorrhage of Cerebrum (bleeding in or around the brain), and Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar).</p> <p>A review of physician order for Resident R90, dated March 30, 2024, revealed an order to cleanse Sacrum with Normal Saline Solution, pack with Calcium Alginate to wound bed, cover with Border Gauze, daily and as needed; every day-shift, for Wound Care, and as needed.</p> <p>An observation of the wound care treatment administered by Licensed nurse, Employee E44 to Resident R90, on April 19, 2024, at 10:32 a.m. revealed that the nurse used the same gauze piece, to cleanse the inside of the wound, after cleaning the peripheral area of the wound.</p> <p>An interview with Licensed nurse, Employee E44, at the time of the finding, confirmed that Licensed nurse, Employee E44 used the same gauze piece, to cleanse the inside of the wound, after cleaning the peripheral area of the wound, which was a break on infection control.</p> <p>28 Pa Code 211.12(d)(1)(5) Nursing services</p>		