

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER Phoebe Richland Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 108 South Main Street Richlandtown, PA 18955	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>43883</p> <p>Based on observation, clinical record review, and resident interview, it was determined that the facility failed to ensure that a functioning call bell was accessible for one of 25 sampled residents. (Resident 14)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 14 had diagnoses that included heart failure, muscle weakness, and chronic respiratory failure. Review of the resident's care plan revealed that he required assistance from staff for activities of daily living and was at risk for falls. The interventions were for staff to ensure that a functioning call bell system was in reach and the resident should be encouraged to use it. On January 28, 2025, from 12:16 p.m. through 12:22 p.m., the resident was observed in his room sitting out of bed. The resident stated that he was soiled and needed to be changed. He also stated that his call bell did not work. The resident pressed the call bell button; the light outside of his room that alerted staff to a need for assistance, did not activate.</p> <p>On January 29, 2025, at 1:48 p.m., the resident was observed in his room out of bed. He stated that he would like ice cream. The resident attempted to reach his call bell. The call bell button was hanging below the resident's bed and out of reach. The resident was again observed at 2:23 p.m., the call bell was in the same position and not accessible to the resident.</p> <p>In an interview on January 31, 2025, at 9:53 a.m., the Administrator stated that the resident's call bell light was not functioning properly and needed to be repaired.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</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 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>43883</p> <p>Based on clinical record review and observation, it was determined that the facility failed to ensure that adaptive equipment was provided to two of three sampled residents who required adaptive equipment with meals. (Residents 6, 24)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 6 had diagnoses that included dysphagia and hemiparesis (muscle weakness to one side of the body) to the right dominant side. Review of the care plan revealed that the resident was at risk for nutritional problems. The intervention was for staff to provide adaptive equipment, which included drinks in a handled mug with a lid. A physician's order dated December 7, 2024, revealed that the resident was to receive adaptive equipment which included handled mugs with lids. On January 29, 2025, during the lunch meal observation from 12:25 p.m. through 1:45 p.m., Resident 6 was observed in the dining room eating her lunch meal. The resident was served beverages in handled mugs; the lids were not in place.</p> <p>Clinical record review revealed that Resident 24 had diagnoses that included dementia, Parkinson's disease, and muscle weakness. Review of the care plan revealed that the resident was at risk for nutritional problems. The intervention was for staff to provide adaptive equipment with meals, which included handled mugs with lids. A physician's order dated October 23, 2024, directed staff to provide a handled mug with a lid. On January 29, 2025, during the lunch meal observation from 12:25 p.m. through 1:45 p.m., Resident 24 was observed in the dining room eating her lunch meal. The resident was served beverages in a handled mug; the lids were not in place.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43883</p> <p>Based on facility policy review, review of facility documentation, observation and interview, it was determined the facility failed to serve and store food in a safe and sanitary manner during meal service in one of six dining rooms. (Country Inn Dining Room).</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Heating Foods and Beverages in the Microwave, revealed that once a food or beverage had been reheated, staff were to remove it from the microwave and take the temperature in multiple sites; food and beverages should have reached a temperature of 165 degrees Fahrenheit (F). The item should be left to cool for two minutes and the temperature should be retaken in multiple sites. The food or beverage would be acceptable to serve if it was within the acceptable serving temperature of 135 degrees F through 165 degrees F.</p> <p>Review of a facility meal temperature log revealed that if a food item's temperature was below 135 degrees F but previous temperature taken within two hours was above 135 degrees F, the food should be reheated to 165 degrees F.</p> <p>Observation of the lunch meal service on January 28, 2025, from 12:25 p.m. through 1:30 p.m., revealed the following:</p> <p>Dietary employees 1 (E1) and 2 (E2) were serving food from the steam table. E1 was observed leaving the service line, turned on the faucet in the sink, and rinsed a knife under. E1 then returned to the tray line and proceeded to serve food without changing her gloves. E1 was observed picking paper meal tickets off the ground, she then returned to serving food without changing her gloves. E2 was observed leaving the service line and touched the refrigerator handle and microwave handle. E2 then proceeded to serve food, that included touching ready to eat bread, without changing her gloves. E2 removed chicken broth from the refrigerator and reheated it in the microwave. E2 then served the chicken broth on a resident meal tray without taking a temperature.</p> <p>During observations of the lunch meal service on January 29, 2025, from 12:21 p.m. through 1:50 p.m., revealed the following:</p> <p>E2 and dietary employee 3 (E3) were observed serving food from the steam table. Both E2 and E3 were observed leaving the tray line area, and opening cabinets to obtain items, and adjusting their glasses and masks. E2 and E3 returned to tray line to continue serving food after touching the handles, glasses and masks without changing their gloves.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>E3 was observed dishing pureed soup into bowls that were placed on a surface beside the heated steam table wells, they were not on a hot holding element. Later in the meal service, E3 poured the contents of those soup bowls back into the large pan of pureed soup that was on the steam table. The temperature of the soup in the bowls was not obtained to determine if they had fallen below 135 degrees F to ascertain if they required to be reheated to 165 degree F. E3 proceeded to mix the pureed soups together and proceeded to dish the soup back into individualized bowls which were served on resident trays. There was no temperature obtained.</p> <p>E2 was preparing sandwiches for resident trays. E2 proceeded to touch her eyeglasses three times without changing her gloves or performing hand hygiene and continued to assemble sandwiches for resident meal trays.</p> <p>Observations of the Country Inn kitchen on January 30, 2025, at 11:55 a.m., revealed the following:</p> <p>There was dirt and debris under the steam table. There was dirt and debris under the dish machine, where clean dish racks were stored. There was a brown substance on the inner walls and top of the microwave.</p> <p>28 Pa. Code 201.18(b)(3) Management.</p>		