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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395041 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/25/2025 |
| NAME OF PROVIDER OR SUPPLIER Twinbrook Healthcare and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 3805 Field Street Erie, PA 16511 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496</p> <p>Based on review of clinical records and staff interview, it was determined that the facility failed to assure physician orders and resident's Pennsylvania Order for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments) were consistent for one of 24 residents reviewed (Resident R78).</p> <p>Findings include:</p> <p>Review of Resident R78's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and gastroesophageal reflux disease (a condition when stomach acid repeatedly flows back up into your throat).</p> <p>Review of Resident R78's POLST, revealed that POLST must be completed by a health care professional based on patient preferences and medical indicators or decisions by the patient or a surrogate, and must be signed by a physician/PA/CRNP and patient/surrogate. Resident R78's POLST revealed his/her name and birthdate, the POLST lacked evidence of his/her and/or his/her representative's advance directive wishes.</p> <p>Review of Resident R78's clinical record revealed an order for Cardiopulmonary Resuscitation (CPR-emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest)- Full Code. Further review of Resident R78's clinical record revealed other than an order for a Full Code, there was no evidence he/she and/or his/her representative was provided written information on advance directives or assisted with the opportunity to formulate advance directives regarding life sustaining treatment regarding his/her health care.</p> <p>During an interview on [DATE], at 10:15 a.m. Registered Nurse (RN) Employee E7 revealed that during an emergent situation the staff refer to resident's paper chart to determine resident life sustaining wishes. RN Employee E7 confirmed that Resident R78's POLST lacked evidence reflecting his/her and/or his/her representative's wishes. RN Employee E7 also confirmed that Resident R78's POLST should have been filled out and signed by the physician to reflect his/her current wishes.</p> <p>28 Pa. Code 201.18 (b)(1) Management</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.5(f)(i) Medical records 28 Pa. Code 211.10(c) Resident care policies |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496</p> <p>Based on review of facility policy, observations, and resident and staff interview, it was determined that the facility failed to maintain a clean and sanitary resident room for three of three rooms (rooms [ROOM NUMBER]).</p> <p>Findings include:</p> <p>Review of facility policy entitled Maintenance Service dated 11/8/24, indicated The maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. and Maintaining the building in good repair and free from hazards.</p> <p>Review of facility policy entitled Safe and Homelike Environment dated 11/8/24, indicated Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment.</p> <p>Observations on 4/22/25, at 2:00 p.m. and again on 4/23/25, at 9:45 a.m. in rooms [ROOM NUMBERS] revealed in room [ROOM NUMBER] a black substance on the wall where the paint had lifted next to the bottom corners of the window sill.</p> <p>Observation of room [ROOM NUMBER] revealed a black substance on the wall in the corners of the window sill and also a black substance on the wall below the window. Further observations in room [ROOM NUMBER] revealed a large area of the wall below the window had the paint peeling off.</p> <p>During an interview on 4/23/25, at 9:55 a.m. with the Maintenance Director, he/she confirmed there was a black substance next to the corners of the windows and on the wall in rooms [ROOM NUMBERS]. He/she confirmed that the paint on the wall in room [ROOM NUMBER] was peeling off. He/she also confirmed that the black substance should not be on the walls and the paint should not be peeling off the wall.</p> <p>During an interview with Resident R65, he/she expressed that his/her bathroom sink has not drained since he/she was admitted in March. He/she expressed that they have to go to another room to get washed up in the morning because the sink in his/her bathroom will not drain.</p> <p>Observations on 4/23/25, at 8:00 a.m. on 4/24/25, at 1:00 p.m. and again on 4/25/25, at 8:55 a.m. of room [ROOM NUMBER]'s bathroom revealed the sink was full of water and not draining. Under the sink was a line of a brown substance running down the wall to the floor. The wall and floor tile under the sink and over to the toilet had a bubbled appearance.</p> <p>During an interview on 4/25/25, at 9:40 a.m. with the Maintenance Director, he/she confirmed that room [ROOM NUMBER]'s bathroom sink was not draining. He/she also confirmed that there was a brown substance running down the wall under the sink and that the wall and floor under the sink and over to the toilet had a bubbled appearance. He/she also confirmed that the sink should drain appropriately, and the wall and floor should not have a bubbling appearance.</p> <p>(continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>28 Pa. Code 201.14 (a) Responsibility of Licensee</p> |

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| <p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496</p> <p>Based on review of facility policy and clinical records and staff interview, it was determined that the facility failed to provide a written summary of the baseline care plan and order summary to the resident and/or representative for two of seven residents reviewed (Residents R59 and R92).</p> <p>Findings include:</p> <p>Review of facility policy entitled Care Plans-Baseline dated 11/8/24, revealed The resident and their representative will be provided a summary of the baseline care plan .</p> <p>Review of Resident R59's clinical record revealed an admitted [DATE], with diagnoses that included diabetes (a health condition that caused by the body's inability to produce enough insulin), and hypertension (high blood pressure).</p> <p>Resident R59's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R59 and/or his/her representative.</p> <p>Review of Resident R92's clinical record revealed an admitted [DATE], with diagnoses that included diabetes, paraplegia (a condition where a person is paralyzed from the waist down), and hypertension.</p> <p>Resident R92's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R92 and/or his/her representative.</p> <p>During an interview on 4/24/25, at 3:35 p.m. Registered Nurse Employee E7 confirmed that the clinical records of Residents R59 and R92 lacked evidence that a written summary of the baseline care plan and order summary were provided the resident and/or his/her representative upon admission to the facility.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> <p>28 Pa. Code 201.18 (b)(1) Management</p> |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496</p> <p>Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to develop comprehensive care plans for one of 21 residents reviewed (Resident R92).</p> <p>Findings include:</p> <p>Review of facility policy entitled Care Plans, Comprehensive Person-Centered dated 11/8/24, revealed Assessments of residents are ongoing, and care plans are revised as information about the resident and the residents' condition change.</p> <p>Review of Resident R92's clinical record revealed an admitted [DATE], with diagnoses that included diabetes (a health condition that caused by the body's inability to produce enough insulin), paraplegia (a condition where a person is paralyzed from the waist down), and hypertension (high blood pressure).</p> <p>Review of Resident R92's therapy discharge summary dated 12/19/24, revealed Patient will safely wear a resting hand splint on left hand for up to 8 hours .</p> <p>Review of resident R92's physician's orders revealed an order dated 12/24/24, for patient to wear palm roll splint 4 hours in the a.m. and 4 hours in the p.m. for contracture management.</p> <p>Review of Resident R92's care plans revealed no evidence of a care plan for the resting hand splint/palm roll splint to left hand.</p> <p>During an interview on 4/25/25, at 11:18 a.m. with the Therapy Director he/she confirmed that Resident R92's plan of care lacked a care plan for resting hand splint/palm roll splint to left hand. He/she also confirmed that a care plan should have been developed for Resident R92's resting hand splint/palm roll splint to left hand.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> | | |

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| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496</p> <p>Based on review of clinical records, observations, and staff interviews, it was determined that the facility failed to ensure that a resident with limited range of motion received physician ordered treatment and services to prevent further decrease in range of motion for one of three residents reviewed (Resident R92).</p> <p>Findings include:</p> <p>Review of Resident R92's clinical record revealed an admitted [DATE], with diagnoses that included diabetes (a health condition that caused by the body's inability to produce enough insulin), paraplegia (a condition where a person is paralyzed from the waist down), and hypertension (high blood pressure).</p> <p>Review of Resident R92's therapy discharge summary dated 12/19/24, revealed Patient will safely wear a resting hand splint (a splint placed on the hand to help with contractures) on left hand for up to 8 hours .</p> <p>Review of Resident R92's physician's orders revealed an order dated 12/24/24, for patient to wear palm roll splint 4 hours in the a.m. and 4 hours in the p.m. for contracture management.</p> <p>Review of Resident R92's documentation lacked evidence that a palm roll splint was applied as ordered.</p> <p>Observations on 4/22/25, at 11:45 a.m. revealed Resident R92 laying in his/her bed with no palm roll splint to left hand; the palm roll splint was observed laying on Resident R92's bedside stand.</p> <p>Observations on 4/23/25, at 8:30 a.m., 11:25 a.m. and again at 12:50 p.m. revealed Resident R92 laying in his/her bed with no palm roll splint to left hand; the palm roll splint was observed laying on his/her bedside stand.</p> <p>Observations on 4/24/25, at 9:00 a.m. and 10:10 a.m. and again at 3:00 p.m. revealed Resident R92 laying in his/her bed with no palm roll splint to left hand; the palm roll splint was not observed to be in room.</p> <p>Observations on 4/24/25, at 3:40 p.m. revealed Resident R92 was sitting in his/her wheelchair outside with no palm roll splint to left hand.</p> <p>Observations on 4/25/25, at 8:55 a.m. and again at 9:45 a.m. revealed Resident R92 laying in his/her bed with no palm roll splint to left hand; the palm roll splint was not observed to be in the room.</p> <p>During an interview on 4/25/25, at 9:45 a.m. the Director of Nursing confirmed that Resident R92 did not have a palm roll splint on his/her left hand per physician's orders. He/she also confirmed that Resident R92 should have his/her palm roll splint to his/her left hand on per physician's orders.</p> <p>(continued on next page)</p> | | |

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| F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.10 (d) Resident care policies 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services |

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| <p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>17260</p> <p>Based on review of facility documents and staff interview, it was determined that the facility failed to have a Director of Nursing (DON) working full-time of 35 hours per week in the building.</p> <p>Findings include:</p> <p>Review of the facility deployment sheets documented that the DON was assigned to work as a charge nurse on 4/22/25, as a floor nurse 4/23/25, and worked on 4/25/25 as a charge nurse.</p> <p>During interview on 4/25/25, at approximately 1:40 p.m. the DON confirmed that he/she worked in the above capacities as documented on the deployment sheets rather than as the DON which did not meet the required hours to fulfill the DON full-time position.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(b) Nursing services</p> |

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| <p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p> | <p>Post nurse staffing information every day.</p> <p>17260</p> <p>Based on observations and staff interview, it was determined that the facility failed to ensure that the required nursing staffing information was posted on a daily basis.</p> <p>Findings include:</p> <p>Observations on 4/25/25 at 10:46 a.m. revealed that the daily staffing posting was not publicly posted in the facility.</p> <p>During interview at the time of the observation, the lack of the posting was confirmed by the Director of Nursing.</p> <p>28 Pa. Code 201.14 (a) Responsibility of Licensee</p> |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48496</p> <p>Based on review of facility policies, observations and staff interviews, it was determined that the facility failed to appropriately discard outdated medications for three of three medication carts reviewed and one of three medication rooms reviewed (West, East One, and South medication carts and East One medication room).</p> <p>Findings include:</p> <p>Review of facility policy entitled Administering Medications dated 11/8/24, indicated The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.</p> <p>Review of manufacturer's guidelines revealed that an open pen of Lispro/Humalog Insulin must be used within 28 days after opening or be discarded.</p> <p>Review of manufacturer's guidelines revealed that an open pen of Lantus Insulin must be used within 28 days after opening or be discarded, even if the vial still contains insulin.</p> <p>Review of manufacturer's guidelines revealed that an open vial of Tubersol should be discarded within 30 days after opening.</p> <p>Observation of drug storage on 4/22/25, at 3:36 p.m. of the [NAME] medication cart revealed an open Lantus Insulin pen with no date indicating when the insulin pen was open.</p> <p>During an interview on 4/22/25, at the time of observation Licensed Practical Nurse (LPN) Employee E3 confirmed that the open Lantus insulin pen lacked an open date, and staff were unable to determine the discard date. He/she also confirmed that the insulin pen should have been discarded.</p> <p>Observation of drug storage on 4/22/25, at 3:46 p.m. of the South medication cart revealed an open Lantus Insulin pen with an open date of 3/15/25.</p> <p>During an interview on 4/22/25, at the time of observation LPN Employee E4 confirmed that the open Lantus insulin pen had an open date of 3/15/25. He/she also confirmed that the open date on the Lantus insulin pen was beyond the 28 days and should have been discarded.</p> <p>Observation of drug storage on 4/22/25, at 3:50 p.m. of the East One medication cart revealed an open Lantus Insulin pen, an open Lantus insulin vial, an open Lispro insulin vial and an open Humalog insulin pen with no dates indicating when the insulin pens and vials were open.</p> <p>During an interview on 4/22/25, at the time of observation LPN Employee E5 confirmed that the open Lantus and Humalog pens, and the open Lantus and Lispro insulin vials lacked open dates, and staff were unable to determine the discard dates. He/she also confirmed that the insulin pens and insulin vials should have been discarded.</p> <p>(continued on next page)</p> |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Observation of drug storage on 4/22/25, at 3:55 p.m. of the East One medication room revealed an open Lantus Insulin vial with no date indicating when the insulin vial was open. Further observations revealed an opened vial of Tubersol (a solution used for tuberculosis testing upon admission and employment) dated 3/5/25.</p> <p>During an interview on 4/22/25, at the time of observation LPN Employee E6 confirmed that the open Lantus insulin vial lacked an open date, and staff were unable to determine the discard date. He/she also confirmed that the open date on the Tubersol vial was beyond the 28 days and that the insulin vial and Tubersol vial should have been discarded.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1) 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 - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41309</p> <p>Based on observations, review of dishwashing machine manufacturer's instructions, and staff interviews, it was determined that the facility failed to maintain dishwashing machine water temperatures in accordance with manufacturer recommendations for food service safety for the kitchen dishwasher.</p> <p>Findings include:</p> <p>Review of manufacturer's instructions for the facility dishwashing machine revealed that the hot water sanitizing mode minimum wash temperature and recommended wash temperature was 150-165 degrees Fahrenheit (F). The rinse temperature was 180-194 degrees F.</p> <p>Review of the Dishwashing/Warewashing machine temperature log sheet revealed that the minimum temperature requirements for the wash cycle was: Wash 150 degrees F and the Rinse 180 degrees F. If temperatures were below standard, the person in charge was notified and dismachine was stopped.</p> <p>Observations of the dishwashing machine operation on 4/25/2025, at 10:10 a.m. in the kitchen dishroom, in the presence of the Dietary Manager, revealed a dishwasher temperature of 152-154 degrees F during the wash cycle and 166-168 degrees F on the rinse cycle. Dietary Manager confirmed, at the time of observation, that the rinse cycle was lower than the required 180 degrees F.</p> <p>Review of dishwasher temperature log for the kitchen for the month of April 2025 revealed that the kitchen dishwashing machine temperatures were not logged for the evening shift for dishwasher temperatures of the wash and rinse cycles for the entire month of April 2025.</p> <p>During an interview on 4/25/2025, at 10:15 a.m. the Dietary Manager confirmed that dishwashing machine temperatures are supposed to meet the 150 degrees F during the wash cycle and 180 degrees during the rinse cycle. Staff should record their readings on the dishwasher temperature log and are to inform management and maintenance if the dishwashing machines do not meet the required temperatures for wash and rinse cycles.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395041 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/25/2025 |
| NAME OF PROVIDER OR SUPPLIER Twinbrook Healthcare and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 3805 Field Street Erie, PA 16511 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|--|
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31185</p> <p>Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to follow acceptable infection control practices regarding enhanced barrier precautions (EBP) for five of five resident units (South East, South, West, East One and East Two units). The facility also failed to prevent the potential for cross-contamination during medication administration and completion of a wound dressing change for two of 21 residents reviewed (Residents R81 and Resident R92).</p> <p>Findings include:</p> <p>A facility policy entitled, Transmission-Based Precautions and Isolation Policy, dated 11/8/24, revealed Enhanced Barrier Precautions (EBP) - EBP are intended to prevent transmission of multi-drug resistant organisms (MDROs) via contaminated hands and clothing of healthcare workers to high risk residents. EBP are indicated for high contact care activities for residents with chronic wounds and indwelling devices (such as central lines, urinary catheters, and tracheostomy) and for all those colonized or infected with a MDRO currently targeted by the CDC. Other MDROs may be included at the discretion of the facility Infection Control Committee unless required by state guidance.</p> <p>A facility policy entitled, Clean Dressing Change, dated 11/8/24, indicated that staff should wash hands and place clean gloves on prior to the procedure and to remove gloves after removing the existing dressing and wash hands and place clean gloves to cleanse the wound.</p> <p>Review of facility policy entitled Administering Medications dated 11/8/24, indicated Staff follows established facility infection control procedures . for the administration of medications .</p> <p>Observations on 4/23/25, at 9:35 a.m. revealed Licensed Practical Nurse (LPN) Employee E2 completing a wound dressing change in Resident R81's room without donning (putting on) a gown. An interview on 4/23/25, at 11:10 a.m. with Registered Nurse (RN) Employee E8 confirmed the LPN should have donned the appropriate Personal Protective Equipment (PPE), gowns and gloves, prior to entering Resident R81's room to provide the wound care due to Resident R81 being in EBP for having a chronic stage three (full thickness loss of skin) right side of foot pressure ulcer. Observations during the dressing change revealed that LPN Employee E2 failed to wash hands prior to the procedure and then removed the dirty dressing from Resident 81's right foot and failed to change gloves and wash hands after removing the soiled dressing. An interview with LPN Employee E2 at the time of the observation, confirmed that he/she did not follow EBP by donning a gown and also failed to wash hands prior and change gloves and wash hands after removing the soiled dressing</p> <p>(continued on next page)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Observations on 4/22/25, at 12:45 p.m. and 4/23/25, at 9:35 a.m., revealed no PPE available at the doorway or in the hallways for EBP for room [ROOM NUMBER] (resident with a foley catheter-tubing entering the bladder to drain urine), room [ROOM NUMBER] (resident with chronic wound), room [ROOM NUMBER] (resident with tube feeding-a medical device that delivers nutrition directly into the stomach), room [ROOM NUMBER] (resident with suprapubic catheter and chronic wound), room [ROOM NUMBER] (resident with a tube feeding), room [ROOM NUMBER] (resident with a tube feeding), room [ROOM NUMBER] (resident with a tube feeding), room [ROOM NUMBER] (resident with a wound), room [ROOM NUMBER] (resident with a PICC line-a long thin tube inserted into a vein to deliver medications) and room [ROOM NUMBER] (resident with a dialysis perma cath-a catheter placed for dialysis treatment).</p> <p>During an interview on 4/23/25, at 11:10 a.m. RN Employee E8 confirmed that employees should be wearing appropriate PPE, such as gloves and gowns, when providing care for residents who are in EBP, and the PPE should be readily available and proper signage should be posted to alert staff that the resident is in EBP.</p> <p>Observations during medication administration on 4/23/25, between 8:00 a.m. and 8:15 a.m. for Resident R92 revealed LPN Employee E1 preparing medications for Resident R92. LPN Employee E1 placed gloves on his/her hands, he/she then proceeded to place one medication at a time into his/her hand and placed the medication into the medication cup. In between each medication he/she touched the medication cart, medication cards, medication bottles, garbage can and touched his/her head while wearing the same gloves. Further observations revealed LPN Employee E1 dropped a medication on top of the medication cart and another medication into the drawer of the medication cart he/she proceeded to pick the medications up and placed them into the medication cup.</p> <p>During an interview on 4/23/25, at the time of observations with LPN Employee E1, he/she confirmed that he/she placed medications into his/her hand after touching several items and not changing his/her gloves. He/she also confirmed that he/she should not place medications into his/her hand after touching several items without changing his/her gloves.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p> | | |