

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Mountain View, A Nursing and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 Trevorton Road Coal Township, PA 17866	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 44738 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to accommodate resident needs regarding the accessibility to a call bell for two of 35 residents reviewed (Residents 17 and 54). Findings include: Clinical record review for Resident 54 revealed a diagnoses list that included: muscle weakness and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following unspecified cerebrovascular disease affecting the left non-dominant side. A current care plan for Resident 54 revealed the resident has a communication problem related to a cerebrovascular accident (stroke). An intervention listed on the care plan included to ensure/provide a safe environment and have the call light in reach. Further review of the care plan for Resident 54 revealed the resident has activities of daily living self-care deficits related to the resident's medical history. An intervention included encouraging the resident to use the call bell to call for assistance. Another care plan for Resident 54 revealed the resident is at risk for falls and an intervention included keeping the call bell in reach and encouraging the resident to ring for assistance. Observation of Resident 54 on June 5, 2024, at 11:20 AM revealed the resident was sitting in a broda-chair at the foot of the bed. The resident was turned away from the bed. The call bell was observed at least five feet behind the resident near the head of the bed and out of reach of the resident. Observation of Resident 54 on June 5, 2024, at 2:09 PM revealed the resident was sitting in a broda-chair at the foot of the bed and positioned looking away from the bed. The resident's call bell was at least five feet away and clipped to near the head of the bed and out of reach of the resident. An interview with Employee 1, nurse aide, on June 5, 2024, at 2:11 PM confirmed the call bell was out of reach for Resident 54. A current care plan for Resident 17 revealed that the resident is at risk for falls related to gait/balance problems. An intervention included to be sure the call light is within reach and encourage the resident to use it for assistance as needed. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident 17 on June 4, 2024, at 11:25 AM revealed the resident reported a history of decreased mobility. An interview and observation with Resident 17 on June 5, 2024, at 2:00 PM revealed the resident was sitting at the foot of the bed in a wheeled chair. The resident stated he was looking for staff to get back in bed and had asked two hours ago. Resident 17 further reported he would ring his call bell but was unable to reach it. The call bell was not obviously visible and was located about three feet away clipped to the side of the mattress on the other side of the bed from Resident 17. The above information for Residents 54 and 17 were reviewed with the Nursing Home Administrator and Director of Nursing on June 6, 2024, at 1:45 PM. 28 Pa. Code 211.12(d)(5) Nursing services		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229 Based on clinical record review and staff interview, it was determined that the facility failed to establish clear and consistent resident wishes regarding advance directives for one of seven residents reviewed (Resident 32). Findings include: Clinical record review revealed the facility admitted Resident 32 on [DATE]. A review of Resident 32's POLST (Physician Orders for Life-Sustaining Treatment, a document for specific medical orders to be honored by health care workers during a medical crisis) form dated [DATE], indicated Resident 32's responsible party chose CPR (cardiopulmonary resuscitation, a lifesaving procedure performed when the heart stops beating). An updated POLST dated [DATE], also indicated Resident 32's responsible party chose CPR. Review of Resident 32's physician orders revealed a current order dated [DATE], indicating that Resident 32 was a limited code, no CPR. A previous physician's order dated February 19, 2024, indicated that Resident 26 was a DNR (do not attempt resuscitation). The surveyor reviewed the findings for Resident 32 during an interview with the Director of Nursing on [DATE], at 8:14 AM. Interview with Employee 3 (assistant director of nursing) verified the POLST in Resident 32's medical record did not match Resident 32's physician orders. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 44738 Based on observations and staff interview, it was determined that the facility failed to ensure confidentiality of personal health information and a resident's right to privacy for one of five nursing units reviewed (Nursing Unit F; Resident 23). Findings include: Observation on June 6, 2024, at 10:21 AM revealed the Nursing Unit F medication/supply room supplies were being restocked by Employee 4, supplies staff. Employee 5, licensed practical nurse (LPN), was also present. Further observation of the medication/supply room revealed a computer on top of a medication cart that was clearly visible to Employee 4 who was a non-clinical staff member. The computer was logged into Resident 23's medical record. An interview with Employee 5 revealed that the computer belonged to Employee 6, LPN, who was not present and currently on break. Employee 6's name was also visible on the screen confirming she was logged into the medical record. It was unclear how long the resident's chart was left unsecured. The above information for Resident 23 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 6, 2024, at 1:45 PM. 28 Pa. Code 211.12(d)(1) Nursing services		

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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** 44738 Based on observation and resident and staff interview, it was determined that the facility failed to provide a clean, comfortable, and homelike environment on four of four nursing units reviewed (Nursing Units A, B, F, and G; Residents 54, 95, 122, and 163). Findings include: Observation of Resident 54's room on the F unit on June 5, 2024, at 2:11 PM revealed an eight inch by eight inch section of wall at the head of the resident's bed that was marred and damaged with the cove base separating from the wall. A pile of dust from the damaged wall was accumulating on the floor underneath the damaged section. A concurrent interview with Employee 1, nurse aide, about Resident 54's damaged wall revealed it was unclear how long the wall has been damaged. The above information for Resident 54 was reviewed with the Nursing Home Administrator and Director of Nursing on June 6, 2024, at 1:45 PM. Observation of G unit on June 4, 2024, at 12:00 PM noted the wall on both sides of the hallway between rooms 10-18 were patched in several areas but not painted. Interview with the Nursing Home Administrator on June 6, 2024, at 2:20 PM revealed that they have been working on the walls but did not get them finished. She was unsure when the walls were patched but did acknowledge that the patched areas were there the week before. Observation of Resident 122's room on the B unit on June 5, 2024, at 10:00 AM revealed that the wall separating the four beds into two beds on each side was severely marred and damaged to the point of the white drywall showing through. The cove basing at the bottom of the wall was either missing or peeling. Interview with Resident 122 at this time indicated that the wall has been like that since she was admitted on [DATE]. Observation of Resident 95 on the A unit on June 5, 2024, at 1:10 PM revealed that they were in bed with fall mats on both sides of the floor. Observation of the fall mat on the side of the bed closest to the window revealed there were multiple brown smears on the mat. Observation of Resident 95's room on June 7, 2024, at 10:10 AM revealed that Resident 95 was out of the room and his fall mats were folded up, leaning against the wall. The brown smears remained on the fall mat. It was also noted that the wall behind Resident 95's bed was marred in several areas. 483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19719 Based on clinical record review, review of select policies and procedures, and staff interview, it was determined that the facility failed to implement their abuse policy regarding completion of a thorough investigation and reporting for allegations of abuse for five of five residents reviewed (Residents 34, 64, 66, 80 and 102). Findings include: The policy entitled Resident Abuse and Neglect Prevention Program reviewed on August 21, 2023, indicates that upon discovery of an allegation of abuse or situation with the potential for abuse or harm, the facility will take all reasonable measures to separate the alleged perpetrator from access to the alleged victim. A written statement will be obtained from the suspect. The facility will investigate bruises/marks of unknown origin for investigation of possible abuse. The policy also indicates that as a part of the reporting requirements, the provider bulletin 22 (PB-22, an electronic form utilized for the submission and investigation for allegations of abuse to the Department of Health) will be completed and submitted within five working days of the incident. Interview with the Director of Nursing on June 6, 2024, at 10:00 AM revealed that the local county aging department sent a representative to the facility on [DATE], indicating that they received an anonymous allegation of abuse that was taking place at the facility. The allegation indicated that Employee 2, nurse aide, was abusing Resident 34, Resident 64, and Resident 102, because they had bruises. The facility submitted a reportable event to the Department of Health on May 29, 2024, and was instructed to complete the PB-22 investigation within the required time frames. Interview with the Director of Nursing on June 7, 2024, at 11:38 AM confirmed that as of this date the facility has not submitted their PB-22 investigation regarding the above allegation brought to them by the county aging department. Review of a report dated January 27, 2024, at 5:30 AM revealed that Resident 66's roommate alleged that Employee 2 manhandled Resident 66 sometime yesterday when putting her to bed. Review of Resident 66's clinical record revealed a nursing note dated January 27, 2024, at 5:21 AM that indicated nursing staff assessed her as having two small areas of red discoloration under both her left and right arms around the pit (arm pit) area. Review of the facility's investigation into the allegation of abuse for Resident 66 dated January 26, 2024, revealed that the facility did obtain a statement from the perpetrator, Employee 2. Review of Employee 2's witness statement dated January 26, 2024, indicated that she did place the resident in bed yesterday by herself. Review of Resident 66's plan of care indicated that Resident 66 had been assessed by the facility as of April 6, 2022, to need the assistance of two caregivers for transfers. There was no documented evidence in the facility's investigation to indicate that the facility identified that Employee 2 was not following her plan of care for transfers or substantiated that neglect took place. The facility did not implement an educational action plan on Employee 2 until June 6, 2024, after the surveyor brought it to the attention of administration that Employee 2 was not following Resident 66's plan of care. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to complete reporting requirements in the required time for allegations of abuse, and thoroughly investigate allegations to substantiate neglect. Clinical record review for Resident 80 revealed a general progress noted dated May 22, 2024, at 8:00 AM that indicated the resident had a bruise to her left lower extremity described as fading and indurated (becoming hard or firm). The note indicated that the resident denied the area was caused by staff and suggested that it may have been bumped during transfers but that the resident cannot recall the event. Further clinical record review for Resident 80 revealed an MDS (Minimum Data Set, an assessment completed at intervals by the facility to determine care needs) assessment completed on May 6, 2024, that indicated her most recent BIMS (Brief Interview for Mental Status) was 4 suggesting severe impairment. Review of the facility's investigation into Resident 80's bruise to her left lower extremity revealed that the facility failed to interview staff to determine the cause of the bruise. An interview with the Director of Nursing on June 7, 2024, at 1:34 PM confirmed that the facility did not complete a full investigation into the cause of Resident 80's bruise on her left lower extremity. The facility failed to conduct a complete investigation into the bruise on Resident 80's left lower extremity, to rule out abuse or neglect. Clinical record review for Resident 34 revealed nursing documentation dated June 4, 2024, at 9:53 AM that licensed practical nurse (LPN) was made aware by the nurse aide providing care that Resident 34 had scattered bruising noted. The nurse visualized a yellow and purple bruise on Resident 34's right upper abdomen measuring 6 centimeters (cm) by 3 cm, a purple bruise on his left abdominal fold area measuring 6 cm by 3 cm, a purple bruise on Resident 34's left thigh measuring 5 cm by 3 cm, and a yellow and purple bruise on his right shoulder measuring 5 cm by 5 cm. The LPN noted she made the registered nurse supervisor aware, and assessed for potential causes and was unable to determine at this time. Nursing documentation by the registered nurse (RN) supervisor on June 4, 2024, at 9:53 AM revealed that the RN was notified by the LPN charge nurse that Resident 34 was noted to have both old and new bruises. There was no assessment in Resident 34's clinical record completed by the RN of Resident 34's bruises. Interview with the Director of Nursing on June 7, 2024, at 1:14 PM revealed that the facility had no investigation to rule out abuse. The Director of Nursing indicated that she had a witness statement from the nurse aide that found the bruises, but nothing else. The facility failed to conduct a timely investigation into Resident 34's bruises. Interview with the Administrator and Director of Nursing on June 7, 2024, at 11:40 AM acknowledged the above findings for Resident 34, 64, 66, and 102. 28 Pa. Code 201.18(b)(1) Management (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.29(a)(c) Resident rights		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19719 Based on review of facility reported incident investigations, review of staff scheduling and timecards, and staff interview, it was determined that the facility failed to protect residents from an alleged perpetrator of abuse during investigation for three of five residents reviewed (Resident 34, 64, and 102). Findings include: Review of the facility policy entitled Resident Abuse and Neglect Prevention Program reviewed on August 21, 2023, indicated that immediately upon discovery of an allegation of abuse or situation with the potential for abuse or harm, the facility will take all reasonable measures to separate the alleged perpetrator from access to the alleged victim. An abuse suspect will be informed of the accusation and will be ordered to leave the area immediately and escorted to a non-resident location. Any employee identified as the alleged perpetrator will be placed on immediate automatic suspension pending the outcome of the investigation. Upon notification of abuse, the staff member is immediately suspended pending the outcome of the investigation. If the alleged perpetrator is a contractor's employee, they should be ordered to leave the facility immediately. The facility is to notify the contractor that a replacement must be provided. Interview with the Director of Nursing on June 6, 2024, at 10:00 AM revealed that the local county aging department sent a representative to the facility on [DATE], indicating that they received an anonymous allegation of abuse that was taking place at the facility. The allegation indicated that Employee 2, nurse aide, was abusing Resident 34, Resident 64, and Resident 102, because they had bruises. Interview with Employee 2, on June 6, 2024, at 11:40 AM revealed that she has been working every day in the facility since May 29, 2024, and working double shifts. Review of Employee 2's work schedule and timecards from May 29, 2024, until June 7, 2024, revealed that she has worked every day straight, for a total of 124 hours in 10 days. Review of the facility's investigation into the May 29, 2024, allegation of resident abuse, revealed that there was no documented evidence that the facility removed Employee 2 from having access to vulnerable residents during an investigation into alleged abuse. Interview with the Director of Nursing on June 7, 2024, at 11:38 AM confirmed the above findings. 28. Pa Code 201.14(a) Responsibility of licensee. 28. Pa Code 201.18(b)(1)(e)(1) Management. 28. Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 18229 Based on clinical record review, written transfer and ombudsman notices, and staff interview, it was determined that the facility failed to ensure that a written notice of a facility initiated hospital transfer and discharge of the resident was provided to the resident, the resident's representative, and ombudsman for one of eight residents sampled (Resident 181). The findings include: Clinical record review revealed the facility admitted Resident 181 on January 12, 2024. Nursing documentation dated March 12, 2024, at 8:30 AM revealed that Resident 181 struck another resident five times in the face with his fist. The local police were notified of Resident 181's violent behavior and arrived at A-Wing for prevention of any further violence. Resident 181 was transferred to the hospital at this time for evaluation and treatment of Resident 181's aggressive behaviors with harm to others. The Nursing Home Administrator contacted the Department of Health on March 14, 2024, at 11:11 AM to report that the facility would not accept Resident 181 back for readmission due to the risk presented to other residents. When the facility decided to discharge Resident 181 while he was still hospitalized , the facility failed to send an updated notice of the discharge to the resident, resident's representative, and ombudsman Interview with the Nursing Home Administrator and Director of Nursing on June 7, 2024, at 10:07 AM confirmed these findings. 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/discharge Previously cited 07/14/23 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 36798 Based on observations, clinical record review, and staff interview, it was determined that the facility failed to provide the necessary treatment and services consistent with professional standards of practice regarding pressure ulcer treatment for one of four residents reviewed (Resident 6) Findings include: Clinical record review for Resident 6 revealed a nutrition progress note dated June 4, 2024, at 7:53 AM that indicated she is followed by a wound care consultant related to a Stage 4 pressure ulcer (an injury to the skin from prolonged pressure on an area that extends to the muscle, tendon, or bone) on the right ischium (a paired bone of the pelvis that forms the lower and back part of the hip bone). Review of a wound consultant progress note dated May 28, 2024, revealed that Resident 6 currently had a Stage 4 pressure ulcer on her right ischium that measured 0.3cm x 0.2 cm with no depth. Review of Resident 6's current physician orders revealed an order for a foam dressing with border to her Stage 4 pressure ulcer on her right ischium. Observation of wound care provided to Resident 6 on June 6, 2024, at 10:00 AM with Employee 11, Licensed practical nurse (LPN), revealed that she cleansed and applied a foam boarder dressing to an open area located on Resident 6's left buttocks. She did not complete a treatment on Resident 6's right ischium. Review of Resident 6's current physician orders noted the order was for a foam boarder dressing to the right ischium. There were no orders to an open area on Resident 6's left buttocks. Observation of Resident 6 at 12:10 PM with Employee 11 confirmed that she completed the treatment to an open area on the left buttock and not the right ischium. Interview with Employee 3, registered nurse, wound nurse, revealed that the area that the treatment is to be completed on is the right ischium, not the left buttock. Concurrent observation of Resident 6's pressure area revealed a pinpoint open area on the right ischium. Employee 3 confirmed that the treatment order is for the right ischium that is almost healed and that the areas on the left buttock are new areas. The Nursing Home Administrator and the Director of Nursing were made aware of concerns with Resident 6's pressure ulcer treatment during a meeting on June 6, 2024, at 2:14 PM. The facility failed to provide the necessary treatment and services consistent with professional standards of practice in regard to pressure ulcer treatments for Resident 6. 483.25(b)(1)(i)(ii) Treatment/svcs to Prevent/heal Pressure Ulcer Previously cited deficiency 8/29/23 (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 19719 Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to provide appropriate treatment and services regarding incontinence and catheter use for two of five residents reviewed (Residents 130 and 152). Findings include: The policy entitled Bladder and Bowel Screening and Assessment, last reviewed on August 21, 2023, indicated that a resident's bowel and bladder status will be evaluated and assessed at the time of admission. A plan of care is initiated based on the findings. The facility will develop a bowel/bladder program as indicated and if appropriate. Review of Resident 130's clinical record revealed a physician order dated October 4, 2023, for nursing staff to remove his catheter once his sacral wound healed and for nursing staff to do a voiding trial. Documentation was present to indicate that his sacral wound healed on January 23, 2024. There was no documented evidence to indicate that nursing staff removed his catheter after January 23, 2024, to initiate a voiding trial. Resident 130 still has his catheter as of June 7, 2024. Review of Resident 152's clinical record revealed the facility admitted him on April 22, 2024. A Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated April 29, 2024, indicated that the facility assessed him as being occasionally incontinent of urine and frequently incontinent of bowel, and that a urinary or bowel toileting program had not been attempted. The facility also assessed Resident 152 as being able to understand others, be understood, having adequate vision and hearing. The MDS indicated that Resident 152 triggered for incontinence and that the facility would proceed to develop a plan of care to address his incontinence. There was no documented evidence in Resident 152's clinical record to indicate that the facility developed a bowel/bladder program or a plan of care to address his incontinence on April 29, 2024. Interview with the Director of Nursing on June 6, 2024, at 10:20 AM confirmed the above findings for Residents 130 and 152. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 44738 Based on employee personnel review and staff interview, it was determined that the facility failed to complete a performance evaluation of each nurse aide at least once every 12 months for three of three nurse aides reviewed (Employees 1, 7, and 8). Findings Include: The facility noted the following hire dates for three employees reviewed for performance evaluations: Employee 1's hire date of April 18, 2023; Employee 7's hire date of March 22, 2023; and Employee 8's hire date of June 6, 2022. A request to review the annual performance evaluations revealed no documented evidence that the facility is completing the evaluations at least once every 12 months. Interview with the Director of Nursing on June 7, 2024, at 1:00 PM confirmed that performance evaluations were not completed on any staff. 28 Pa. Code 201.19 (2) Personnel policies and procedures		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229 Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by three of three residents reviewed (Residents 32, 90, and 163). Findings include: Clinical record review for Resident 32 revealed that the facility admitted him on July 28, 2022, with diagnoses including dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life) with other behavioral disturbances being added on March 7, 2023. A review of Resident 32's most recent Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated April 8, 2024, indicated that the facility assessed Resident 32 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed. A review of Resident 32's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. Clinical record review for Resident 90 revealed that the facility admitted him on August 28, 2017, with diagnoses including dementia being added June 7, 2021. A review of Resident 32's most recent MDS dated [DATE], indicated that the facility assessed Resident 32 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed. A review of Resident 90's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. The findings were reviewed with the Director of Nursing on June 7, 2024, at 8:03 AM. She confirmed the facility had no further documentation that the facility developed and implemented an individualized person-centered care plan to address Residents 32 or 90's dementia and cognitive loss. Clinical record review for Resident 163 revealed that the facility admitted her on December 8, 2023. On February 29, 2024, her physician added a diagnosis of dementia to her medical diagnosis. A review of Resident 163's's most recent Significant change MDS dated [DATE], indicated that the facility assessed Resident 163 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed. A review of Resident 163's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia. (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The findings were reviewed with the Director of Nursing on June 6, 2024, at 2:17 PM. She confirmed the facility had no further documentation that the facility developed and implemented an individualized person-centered care plan to address Resident 163's dementia. 483.40(b)(3) Dementia Treatment and Services Previously cited 7/14/23. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 19719 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident's attending physician addressed pharmacy recommendations for five of seven residents reviewed (Residents 32, 43, 55, 130, and 165). Findings include: Review of Resident 130's clinical record revealed that the pharmacist made recommendations to his physician on October 17, 2023, February 20, 2024, and March 27, 2024. There was no documented evidence in Resident 130's clinical record to indicate that the recommendations were acted upon. Interview with the Director of Nursing (DON) on June 7, 2024, at 12:13 PM confirmed the findings for Resident 130. The DON indicated that the facility cannot find the recommendations that were made by the pharmacist on those dates. Review of Resident 165's clinical record revealed a pharmacy recommendation dated February 19, 2024, that indicated Resident 130 is on Alprazolam 0.5 mg (milligrams) every six hour as needed for anxiety, and that all as needed psychoactive medications must have a stop date and a rationale. Resident 165's physician responded on February 29, 2024, indicating that he will use this dosage until she improves. Resident 165 continues to have an order for as needed Alprazolam as of June 7, 2024. There was no documented evidence that Resident 165's physician evaluated the effective use of her psychoactive medication, provided a stop date, or provided a medical rational for its extended use. Review of Resident 165's clinical record revealed a pharmacy recommendation dated March 18, 2024, that indicated Resident 165 is being treated with Cipro (medication used to treat a variety of infections) 500 mg for 10 days. The pharmacist indicated that the use of Cipro is being limited due to serious side effects including central nervous system effects. The pharmacist recommended to use the Cipro for a limited time or use Bactrim DS (another medication used to treat infections) for three to five days. Resident 165's physician responded to the pharmacy recommendation indicating to discontinue Keflex (a different medication used to treat infections). Resident 165 did not have a current order for Keflex at the time of the recommendation. There was no documented evidence that Resident 165's physician provided an appropriate response to the pharmacy recommendation for a change in antibiotic to treat her urinary infection. Interview with the Administrator and Director of Nursing on June 6, 2024, at 1:45 PM confirmed the above findings for Resident 130 and Resident 165. Review of Resident 43's clinical record revealed that the pharmacist made recommendations and noted see separate report, on May 30, 2024, and March 27, 2024. There was no documented evidence in Resident 43's clinical record to indicate that the recommendations were acted upon. Interview with the Director of Nursing on June 7, 2024, at 12:19 PM, confirmed the findings for Resident 43 and indicated that the facility was unable to find the recommendations. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 32's clinical record revealed that the pharmacist made recommendations to her physician on September 29, 2023, November 20, 2023, December 20, 2023, January 19, 2024, February 19, 2024, and March 28, 2024. There was no documented evidence in Resident 32's clinical record to indicate that the recommendations were acted upon. An interview with the Director of Nursing on June 7, 2024, at 1:28 PM confirmed the findings for Resident 32 and indicated that the facility cannot find the recommendations that were made by the pharmacist on those dates. Review of Resident 55's clinical record revealed that the pharmacist made a recommendation to her physician on March 28, 2024. There was no documented evidence in Resident 55's clinical record to indicate that the recommendation was acted upon. An interview with the Director of Nursing on June 7, 2024, at 12:16 PM confirmed the findings for Resident 55 and indicated that the facility cannot find the recommendations that were made by the pharmacist on that date. 28 Pa. Code 211.9 (d)(k) Pharmacy services 28 Pa. Code 211.12(d)(3)(5) Nursing services		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 36798 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medications for three of five residents reviewed (Residents 55, 130, and 163). Findings include: Review of Resident 130's clinical record revealed a physician's order dated October 16, 2023, for nursing staff to administer Haldol 2 mg (milligrams) every four hours as needed and Ativan 0.5 mg every four hours as needed, both are indicated to be used for agitation. There was no documented evidence in Resident 130's clinical record to indicate that Resident 130's orders for psychoactive as needed medications contained the required 14 day use limit, or that the facility clarified the orders regarding use of multiple medications for the same indication. Interview with the Director of Nursing on June 7, 2024, at 12:13 PM confirmed the above findings for Resident 130. Clinical record review for Resident 163 revealed that the facility admitted her on December 8, 2023, with diagnosis of anxiety (a feeling of fear, dread, and uneasiness), spinal stenosis (when the space around your spinal cord becomes too narrow), and hypertension (high blood pressure). A drug regimen review completed on December 11, 2023, noted an inappropriate diagnosis for Quetiapine (a medication used for the treatment of mental health conditions to include schizophrenia and bipolar disorder) for Resident 163. The inappropriate diagnosis was identified as anxiety. The form also indicated that done and was signed by the physician on December 22, 2023. Interview of the Director of Nursing on June 11, 2024, at 9:40 AM confirmed that done meant the physician took care of the inappropriate diagnosis. A pharmacy review note to the attending physician dated February 2, 2024, revealed that Resident 163 receives Quetiapine 200 mg twice a day for a listed diagnosis of Anxiety and suggested the physician change the diagnosis to an approved diagnosis. The physician agreed on February 29, 2024. An appropriate diagnosis for Quetiapine was never received until February 29, 2024. The facility failed to act on Resident 163's pharmacy recommendation from December 11, 2023, and an appropriate diagnosis for Resident 163's Quetiapine medication was never noted until February 29, 2024. The Director of Nursing was made aware of the concerns with Resident 163's pharmacy recommendation related to her Quetiapine medication during a meeting on June 6, 2024, at 2:15 PM. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review for Resident 55 revealed the facility admitted her on January 8, 2024. A review of the consultant pharmacist's recommendation dated January 19, 2024, revealed Resident 55 was receiving the antipsychotic agent Olanzapine (antipsychotic medication used to treat mental disorders) 2.5 mg three times a day. The consultant pharmacist requested the facility clarify the diagnosis, as the current diagnosis was listed as preventative measures. A review of the physician response dated February 5, 2024, noted Please add a diagnosis of schizoaffective disorder. Further review of Resident 55's clinical record revealed no evidence that Resident 55 was ever diagnosed with schizoaffective disorder by a qualified practitioner using evidence-based criteria and professional standards. Further review of Resident 55's clinical record revealed that the facility added the schizoaffective diagnosis on February 5, 2024. An interview with the Director of Nursing on June 7, 2024, at 10:12 AM confirmed these findings. 483.45(d)(e)(1)-(2) Drug Regimen is Free From Unnecessary Drugs Previously cited deficiency 8/29/23 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 44738 Based on select facility policies and procedures, observation, and staff interview, it was determined that the facility failed to properly store resident medications on two of five nursing units (Unit B and Unit F). Findings include: Review of the policy titled, Medication Storage in the Facility, last reviewed without changes on August 21, 2023, revealed that medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations, or those of the supplier. The section titled Temperature revealed that medications and biologicals are stored at the appropriate temperatures and humidity according to the United States Pharmacopeia guidelines for temperature ranges. Further review of this section revealed the facility should maintain a temperature log in the storage area to record temperatures at least once a day. Further review of the policy revealed a section titled Procedures that indicated only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. Observation of the B unit on June 6, 2024, at 12:31 PM revealed an unlocked and unsupervised medication cart. The cart was full of prescription and over the counter medications accessible to visitors, unlicensed staff, and residents. The medication cart continued to be unlocked and accessible until 12:36 PM, when Employee 12, licensed practical nurse, walked around the corner of the hallway and said, It's not my cart, but I will lock it. Observation of the Unit F medication room on June 6, 2024, at 10:15 AM revealed a small refrigerator used to store medications that required refrigeration. The refrigerator held multiple insulin (a medication used to regulate the blood sugar) pens and suppositories (a medication designed to be inserted rectally to dissolve). A review of the document titled, Temperature Log for Refrigerator - Fahrenheit, revealed the following temperature documentation missing: April 6, 7, 9, 10, 13, 15, 16, 17, 19, 21, 22, 25, 27, 28, 29, 30, 2024. May 2, 3, 5, 8, 9, 14, 15, 17, 19, 21, 23, 25, 27, 28, 29, 30, 31, 2024. June 2, 4, 2024. Further review of the documentation noted to, Take action if temp is out of range - too warm (above 46 degrees Fahrenheit) or too cold (below 36 degrees Fahrenheit). (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff documented the temperature on April 18, 2024, as 34 degrees, which is two degrees below the acceptable range. A temperature below 36 degrees Fahrenheit noted, Danger! Temperatures below 36 degrees are too cold! Write any out-of-range temps and room temp on the lines below and call your state or local health department immediately. There were no notations by staff on the temperature documentation to indicate the low temperature was addressed further. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 6, 2024, at 1:45 PM. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 18229 Based on observation, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to store food and maintain equipment in a sanitary manner to prevent the potential spread of foodborne illness in the facility's main kitchen. Findings included: An observation of the facility's main kitchen with Employee 9 (certified dietary manager) on June 5, 2024, at 9:32 AM revealed the following: Observation of the spices rack revealed a container of parsley dated June 22, 2022, ground cumin dated March 2021, and a container of browning and seasoning sauce with no date. A review of the facility policy entitled Food Storage, last reviewed without changes on August 21, 2023, revealed that these spices should have been discarded six months after opening. Observation of the first oven revealed grease spills down the front of the oven. The second oven had water on the floor in front of it, with pink rags on the tray below. Observation of the dry storage room revealed two bags of egg noodles opened and undated. Observation of the walk-in freezer revealed scraps of trash and spilled peas on the floor. Observation of the juice machine revealed there was liquid on the counter in front of the machine, wet rags on the counter, and what appeared to be water on the floor. An interview with Employee 9 on June 5, 2024, confirmed these findings. He stated that whenever it is hot out, the machines produce condensation and leak as observed. The above information was reviewed with the Nursing Home Administrator on June 7, 2024, at 1:24 PM. 483.60 (i)(2) Food storage safe and sanitary Previously cited 7/14/23 28 Pa. Code 201.14(a) Responsibility of licensee		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 36798 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident received or was offered pneumococcal conjugate vaccines for two of five residents reviewed for immunization concerns (Residents 7 and 89). Findings include: Clinical record review for Resident 7 revealed that the facility admitted her on August 7, 2020. Review of her immunizations in her clinical record revealed that there was no documentation related to the pneumococcal conjugate vaccines (vaccines administered to prevent pneumonia). Interview with Employee 10, Registered Nurse, Infection Preventionist, on June 7, 2024, at 12:45 PM revealed that she had received consent on May 1, 2024, for Resident 7 to have the pneumococcal vaccine but that the vaccine was not given to Resident 7. Clinical record review for Resident 89 revealed that the facility admitted her on July 18, 2017. The clinical record indicated that Resident 89 refused the pneumococcal vaccine because she already had it on September 14, 2016. There was no other documentation available to the surveyor in the clinical record to indicate that the facility offered Resident 89 any further pneumococcal vaccines. On June 7, 2024, at 11:30 AM Employee 10 provided a consent form signed by Resident 89's responsible party on April 30, 2024, indicating that she wanted her to have the pneumococcal vaccine as ordered by her attending physician. Interview with Employee 10 on June 7, 2024, at 12:50 PM revealed that she had received consent on April 30, 2024, for Resident 89 to have the pneumococcal vaccine, but that the vaccine was not given to her. Interview with Employee 10, on June 7, 2024, at 12:55 PM confirmed that Resident 89 and Resident 178 did not receive the pneumococcal vaccine even though consent was given to administer the vaccine. The Director of Nursing was made aware of concerns with Resident 7 and 89's pneumococcal vaccinations on June 7, 2024, at 1:00 PM. The facility failed to ensure the Residents 7 and 89 received the appropriate vaccinations as recommended. 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations Previously cited deficiency 08/29/23 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management (continued on next page)		

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