

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Pine View Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 50 North Malin Road Broomall, PA 19008	

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 0606</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not hire anyone with a finding of abuse, neglect, exploitation, or theft.</p> <p>35913</p> <p>Based upon review of personnel records, it was determined the facility failed to obtain an FBI clearance for one of one employee reviewed (Employee E6).</p> <p>Findings include:</p> <p>Review of Employee E6's personnel file revealed Employee E6 was hired on April 24, 2024 and indicated they had not resided within the Commonwealth of Pennsylvania during the previous two years.</p> <p>Further review of Employee E6's personnel file failed to reveal evidence of an FBI background clearance.</p> <p>Interview with Employee E3 on August 28, 2024, at 11:00 a.m. revealed that the facility failed to obtain an FBI background clearance for Employee E6.</p> <p>The above information was conveyed to the Nursing Home Administrator and Director of Nursing on August 28, 2024, at 11:15 a.m.</p> <p>28 Pa. Code 201.18(b)(1)(2) Management</p> <p>Previously cited 9/26/2023, 1/17/2024</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>41765</p> <p>Based on review of the facility's policy, clinical records, and staff interviews, it was determined the facility failed to comprehensively investigate an unknown injury for one of the three residents reviewed (Resident 146).</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse Prevention Program revised in 2016, revealed, the administrator will ensure that all injuries are investigated. Injury of unknown source is defined as an injury that meets the following: The injury was not observed by any person, or the source of the injury could not be explained by the resident. The Director of Nursing (DON) or a designee will assess all injuries and document clinical findings in the clinical record. The investigator will compile a list of all personnel, including consultants, contract employees, visitors, family members, etc., who had contact with residents during the past 48 hours.</p> <p>Review of Resident 146's diagnoses including Alzheimer's disease (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability), Psychosis (severe mental disorder in which thoughts and emotions are so impaired that contact is lost with external reality) with violent behavior.</p> <p>Review of the Resident 146's Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) dated July 8, 2024, revealed the resident had a severe cognitive impairment. An additional review of the MDS revealed that the resident was independent with ambulating.</p> <p>Review of Resident 146's current care plan revealed resident had combative behavior toward staff when providing care and when being redirected. The resident also had a care plan for wandering behavior and entering other resident's rooms.</p> <p>Review of Resident 146's nursing progress notes dated July 12, 2024, at 7:32 p.m., revealed Resident 146 was seated in front of the nursing station when he/she attempted to walk and fell on the floor. The resident did not hit his head, a minor skin tear was observed on the left leg.</p> <p>Review of facility documentation and licensed Employee E4 statement revealed Resident 146 was sitting in a wheelchair close to the nursing station. The resident refused to sit, tried to stand up, and fell backward into a sitting position.</p> <p>Review of Resident 146's nursing progress notes dated July 13, 2024, at 8:46 p.m., revealed the resident's spouse approached the nurse at 7:45 p.m., and stated that the resident was noticed with a bruise above the right eye. The resident's wife stated that a phone call was received yesterday regarding a fall but was not informed regarding a bruise above the eye.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 146's nursing progress notes dated July 14, 2024, at 8:06 a.m., revealed resident has a hematoma (collection of blood that pools outside of blood vessels in an organ, tissue, or body space) of unknown origin to the right eyebrow. No signs of pain/discomfort, staff sitting with the resident to maintain safety.</p> <p>Review of the facility's documentation and investigation of the right eye bruise failed to reveal that a thorough investigation was conducted. A statement from Employee E4, who worked on July 13, 2024, during the 3-11 shift was taken. No other statements were taken from other staff that had contact with the resident from previous shifts and days.</p> <p>Interview conducted with the Director of Nursing on August 28, 2024, at 11:30 a.m., indicated the right eye bruise was from the fall the day before despite clinical records documentation that the fall was witnessed, and the resident did not hit his/her head. It was also conveyed to the DON that as per the employee statement, Resident 146 fell backward into a sitting position with no indication that the resident's head was hit. The DON confirmed that aside from one statement provided to the surveyor there were no other staff statements taken.</p> <p>The facility failed to ensure Resident 146's right above eye bruise was thoroughly investigated.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.10(c) Resident Care Policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>35913</p> <p>Based on clinical record review and staff interview, it was determined the facility failed to timely obtain a urine specimen for testing according to physician orders for one of 32 residents reviewed. (Resident 58)</p> <p>Findings include:</p> <p>Review of Resident 58's clinical record revealed a progress note dated July 30, 2024, at 2:01 p.m. which indicated During afternoon rounds, resident appeared lethargic; resident will answer to name being called but more confused than (his/her) regular baseline. Resident will occasionally jerk but is unaware of jerking when asked. Call placed to MD (Medical Doctor), spoke to NP (Nurse Practitioner); NP stated MD will be notified. Awaiting call back.</p> <p>Further review of Resident 58's progress notes revealed on July 31, 2024, at 2:47 p.m. Still awaiting call from MD about resident confusion and not being (his/her) regular baseline. Resident occasionally jerk and appears to be more confused than normal.</p> <p>Review of Resident 58's August 2024 physician orders revealed an order dated August 2, 2024, UA/CS ASAP [urinalysis/culture and sensitivity as soon as possible].</p> <p>Review of August 2024 Medication Administration Record (MAR) dated August 2, 2024, revealed Straight cath (catheter) as needed for urine analysis one time only.</p> <p>Review of Resident 58's progress notes dated August 4, 2024, at 6:55 a.m. revealed Resident still needs urine for the UA C & S order by doctor. Dayshift will try to obtain urine. Nursing will continue to monitor.</p> <p>Clinical record review revealed a urine specimen was obtained on August 4, 2024, during the day shift.</p> <p>Further review of the clinical record revealed on August 6, 2024, Resident 58 received an order for Cipro (antibiotic) 500 milligrams (mg) for treatment of a urinary tract infection.</p> <p>Interview with the Director of Nursing on August 28, 2024, at 11:30 a.m. confirmed the facility did not obtain the urine specimen as ordered by the physician in a timely manner which delayed the beginning of treatment for a urinary tract infection from July 31, 2024, until August 6, 2024.</p> <p>28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services</p> <p>Previously cited 3/19/2024</p>

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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>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>46166</p> <p>Based on review of clinical records, facility documentation, observations and staff interview it was determined the facility failed to provide care and services to prevent the development and/or worsening of pressure ulcer and promote healing for one of 31 residents sampled (Resident 103).</p> <p>Findings include:</p> <p>Review of Resident 103's clinical record revealed the resident was admitted to the facility was on August 20, 2021, with diagnoses that included Muscle Weakness (decrease in muscle strength), Dysphagia following cerebral infraction (difficulty swallowing after stroke), Hemiplegia and Hemiparesis following cerebral infraction affecting right dominant side (paralysis of the entire right side of the body), Gastrostomy status (tube feed), bedridden (confined to bed), and Type 2 Diabetes Mellitus (long-term condition where the body doesn't properly regulate and use sugar).</p> <p>Review of Resident 103's clinical record revealed a progress note dated April 29, 2024, at 4:42 a.m. Resident have some redness around stoma (site where peg tube enters the body), G/T (Gastrostomy tube) is intact/patent and dressing applied. No concern of pain/discomfort and or distress noted.</p> <p>Review of Resident 103's care plan initiated June 24, 2024, revealed the resident was at risk for alteration in skin integrity related to impaired mobility, incontinence, and diabetes mellitus, with interventions which included monitor skin integrity, complete a full body check weekly, and check all of body for breaks in skin and treat promptly as ordered by doctor.</p> <p>Additional review of Resident 103's progress notes revealed a nursing progress note dated May 3, 2024, bleeding noted to peg tube site, area cleanse with normal saline. Split gauze in place. Pain noted to site, upon palpitation. PRN (as needed) Tylenol given via peg tube (feeding tube), resident in bed resting at this time.</p> <p>Review of facility form titled GDNWOUND - Weekly observation tool dated May 7, 2024, at 1:51 a.m., revealed Resident 103 had a Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without Slough) located at the peg tube site located on Resident 103's abdomen. Initial measurements of the Stage II pressure ulcer were 2.0 cm (centimeters) x 1.0 cm x 0.1 cm. Additional review revealed a treatment plan of wound cleanser and split gauze daily and as needed.</p> <p>Additional review of Resident 103's progress notes revealed a nursing progress note dated June 18, 2024, at 4:08 p.m. Stage II wound at peg site has been resolved on June 18, 2024.</p> <p>Interview conducted with the Director of Nursing (DON) on August 28, 2024, at 10:01 a.m. was unable to provide evidence of skin prep/treatment/observations of Resident 103's peg tube site from April 29, 2024, through May 7, 2024.</p> <p>Interview conducted with the Director of Nursing on August 28, 2024, at approximately 11:10 a.m., confirmed the facility failed to properly assess/treat Resident 103's peg tube site which resulted in a stage II pressure ulcer.</p> <p>(continued on next page)</p>		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(3)(5) Nursing services

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>22502</p> <p>Based on facility policy, clinical record review, and staff interview, it was determined the facility failed to obtain and monitor weights for one of 12 residents reviewed for nutrition (Resident 83).</p> <p>Findings include:</p> <p>Review of facility policy, Weight and Weight Change Management, revised 2024, revealed each patient will be weighed monthly or more frequently as deemed necessary by Physician's order, Dietitian, or IDT [interdisciplinary team]. Residents with a suspected weight change (per MDS [Minimum Data Set - periodic assessment of resident needs] guidelines) will have a re-weight completed in a timely manner. All confirmed re-weights will be documented in the electronic medical record.</p> <p>Review of Resident 83's clinical record revealed a weight of 164.4 pounds on July 3, 2024. Resident's weight was recorded as 150.0 pounds on August 1, 2024, a loss of 14.4 pounds or 8.8%.</p> <p>Further review of the clinical record revealed a weight change note on August 16, 2024, (15 days after the weight was obtained) indicated the resident triggered for a significant weight loss over 30 days and questioned the accuracy of the weight loss.</p> <p>Further weights were recommended to assess the validity of the weight status. No additional weights were obtained as of August 28, 2024 (12 days after the recommendation).</p> <p>Interview with the Director of Nursing on August 28, 2024, at 12:20 p.m. confirmed a re-weight should have been completed, but was not.</p> <p>483.25 Quality of Care Nutrition/Hydration Status Maintenance</p> <p>Previously cited 9/26/23</p> <p>28 Pa. Code 211.5(f) Clinical Records</p> <p>Previously 9/26/23</p> <p>28 Pa. Code 211.10(c) Resident Care Policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>41765</p> <p>Based on hospital records review, clinical records review, and staff interview, it was determined that the facility failed to ensure appropriate diagnosis for Antipsychotic medication and failed to attempt nonpharmacological intervention and appropriate indication for administration of as-needed anti-anxiety medication for one of five residents reviewed (Resident 73).</p> <p>Findings include:</p> <p>Review of Resident 73's physician orders dated June 18, 2024, revealed an order for Lorazepam (Anti-anxiety medication) 0.5 mg one tablet every 12 hours as needed for agitation.</p> <p>Review of Resident 73's June 2024, Medication Administration Record (MAR) revealed from June 18, 2024, until June 24, 2024, the resident was administered as-needed Lorazepam five times.</p> <p>Review of Resident 73's clinical records revealed that aside from agitation there were no appropriate indications as to why Lorazepam was administered to the resident. Additional review failed to reveal that non-pharmacological interventions were attempted before administering Lorazepam to Resident 73.</p> <p>Interview conducted with the Director of Nursing conducted on August 28, 2024, at 10:00 a.m., confirmed that there was no documentation of appropriate indications and non-pharmacological interventions before administering as-needed Lorazepam to Resident 73.</p> <p>Review of the hospital records dated July 19, 2024, revealed upon discharge, new medications, Trazadone (Anti-depressant medication) and Seroquel were ordered to promote sleep and reduce agitation.</p> <p>Review of the physician's order dated July 19, 2024, revealed an order for Quetiapine (Seroquel) Fumarate 25 mg given 0.5 tablets every eight hours as needed for agitation.</p> <p>Review of Resident 73's July 2024, MAR revealed resident was administered as-needed Seroquel three times.</p> <p>Review of Resident 73's August 2024, MAR revealed resident was administered as-needed Seroquel six times.</p> <p>Interview conducted with the Director of Nursing on August 28, 2024, revealed the Director of Nursing was unable to provide documentation of an appropriate diagnosis for the Antipsychotic medication Seroquel.</p> <p>The facility failed to ensure Resident 73 had an appropriate diagnosis for the use of Antipsychotic medication, and appropriate indications and attempts to provide non-pharmacological interventions were provided before administering as needed Lorazepam.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services</p>