STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395094	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berks County Home- Berks Heim	1011 Berks Road Leesport, PA 19533

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45244 Based on clinical record review and staff interview, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS) assessment for two of 36 sampled residents. (Residents 60, 65) Findings include: Clinical record review revealed that section P of the MDS assessment dated [DATE], indicated that Resident 60 used a trunk restraint while in chair or out of bed daily during the seven-day review period. Review of Resident 60's clinical record revealed that Resident 60 did not have a physician's order for and did not use a trunk restraint while in chair or out of bed during the seven-day review period, as inaccurately identified on the MDS assessment. Clinical record review revealed that Resident 65 had diagnoses that included end stage renal disease. Review of Resident 65's care plan revealed she required hemodialysis. On November 7, 2022, the physician ordered for the resident to receive dialysis on Mondays, Wednesdays, and Fridays. Review of the MDS assessment, dated August 29, 2024, did not indicate that Resident 65 received dialysis.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 17709 Based on clinical record review and review of facility documentation, it was determined that the facility failed to ensure that assessed safety interventions were in place to prevent falls for one of seven sampled residents who were at risk for falls. (Resident 152) Findings include: Clinical record review revealed that Resident 152 had diagnoses that included anxiety, a history of falling, abnormal gait and mobility, a lack of coordination, and unsteadiness on her feet. The Minimum Data Set assessments dated June 6, 2024, and August 2, 2024, indicated that the resident had some memory impairment, used a walker, and had experienced two or more falls during both of the assessment periods. Review of the care plan revealed that the resident was at risk for falls due to being unaware of her safety needs. There was an intervention from March 1, 2024, for staff to ensure that the resident wore appropriate footwear when ambulating. There was another intervention from June 18, 2024, for staff to encourage the resident to wear non-skid socks at night. Review of nursing documentation revealed that the resident had fallen six times on the evening shift from July through September 2024. Review of facility documentation dated September 5, 2024, revealed that at 9:34 p.m., the resident had been walking on the nursing unit with her wheeled walker. The resident fell backwards and hit her head on the floor. The resident had been wearing regular socks. The interdisciplinary review of the fall revealed that the facility had failed to ensure that the resident had appropriate, non-skid footwear on when she had been walking on the nursing unit. CFR 483,25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Previously cited 10/20/23 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709 Based on clinical record review and staff interview, it was determined that the facility failed to document the rationale for the continued use of as needed (PRN) anti-anxiety medications for two of five sampled residents who were on psychotropic medications. (Residents 40, 51) Findings include: Clinical record review revealed that Resident 40 had diagnoses that included dementia with behavioral disturbance and anxiety. On February 19, 2023, a physician ordered for staff to apply an anti-anxiety gel (Ativan gel) PRN for anxiety and the order was still current for the PRN medication. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident had memory impairment and had been administered an anti-anxiety medication in the last seven days of the assessment period. Review of the Medication Administration Records (MAR) revealed that staff had administered the PRN anti-anxiety medication 13 times in June, nine times in July, seven times in August, and nine times in September 2024. There was no documentation in the clinical record from the physician for the rationale to extend the PRN Ativan gel beyond 14 days from the original order on February 19, 2023. Clinical record review revealed that Resident 51 had diagnoses that included Alzheimer's disease and anxiety disorders. On March 22, 2024, a physician ordered for staff to administer an anti-anxiety medication (Ativan) every four hours PRN for anxiety. The MDS assessment dated [DATE], indicated that the resident had memory impairment and had been administered an anti-anxiety medication in the last seven days. Review of the MAR revealed that staff had administered the PRN anti-anxiety medication two times in June, one time in July, eight times in August, and three times in September 2024. There was no documentation in the clinical record from the physician for the rationale to extend the PRN Ativan beyond 14 days from the original order on March 22, 2024. In addition, review of pharmacy recommendations for Resident 51 revealed that on May 27, 2024, and again on June 17, 2024, the pharmacist recommended to include the duration of time for the Ativan PRN order. The physician failed to acknowledge both recommendations and failed to act upon the recommendations in a timely manner related to the use of the PRN Ativan. In an interview on September 19, 2024, the Director of Nursing confirmed that there was no stop date or rationale in the orders to continue to extend the PRN Ativan for either resident. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 17709 Based on facility policy review, observation, and staff interview, it was determined that the facility failed to store foods in a sanitary manner in the dietary department to prevent the potential for foodborne illness. Findings include: Review of the facility policy entitled, Storing: Food and Equipment, last reviewed March 14, 2024, revealed that food was to be stored in a manner that ensured quality and freshness and safeguarded against foodborne illness. The policy indicated that staff was to ensure all food items were labeled. The label was to include product name, use by date, and date the product was prepared or opened. If applicable, the label was to include the date frozen or thawed. Containers were to be covered, labeled, and dated. All food bins were to be covered. Observation during the initial tour of the dietary department on September 17, 2024, at 9:45 a.m., revealed the following: Warming Cabinet (large, tall warming oven) #1 had five containers of prepared food items that were not labeled or dated. The Dietary manager had to uncover the containers to identify the food that was in them and she was not aware of when the containers had been placed in the warming cabinet. Warming Cabinet #2 had a container of pureed chicken that was not dated. There were also several mugs of fortified food that were not labeled or dated. In addition, there was a container of ground chicken that was not dated. On the other side of the warming cabinets in the dietary department, there were air curtain refrigerators. The Dietary Manager stated that staff was to place prepared food on trays inside of the air curtain refrigerators. The staff was to cover, label, and date the food items on these trays. Air curtain refrigerator #1 had five trays of multiple cups of regular prepared peppered cabbage. None of the cups were covered or dated. There were two trays of several cups of pureed peppered cabbage that were not covered or dated. There was a tray with several bowls of tossed salad that were not labeled or dated. Air curtain refrigerator #2 had nine trays of several cups of desserts that were not labeled, dated, or covered. In another large refrigerator in the dietary department, there were seven trays of several dishes of desserts that were not covered, labeled, or dated. In an interview on September 17, 2024, at 10:00 a.m., the Dietary Manager stated that all prepared foods were to be covered, labeled, and dated as per facility policy and standards of practice to prevent foodborne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	201.14(a) Responsibility of licensee.