

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER River View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1555 East End Boulevard Plains Twp Wilkes Barre, PA 18711	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on resident and staff interviews, it was determined that the facility failed to provide care in a manner and environment that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by nine out of the 11 residents during a resident group interview (Residents 6, 18, 24, 37, 41, 51, 83, 107, and 114).</p> <p>Findings include:</p> <p>During a resident group interview with alert and oriented residents on June 12, 2024, at 10:00 AM, the residents in attendance expressed concerns regarding the long wait times for staff to provide assistance with their care when requested/needed.</p> <p>During the resident group interview, Resident 6 stated that when she needs assistance for care, she waits 15 to 20 minutes for staff to provide the needed care.</p> <p>During the resident group interview, Resident 18 stated that she waits a very long time for staff to provide needed assistance with care. She explained that staff will sometimes initially respond to her calls for assistance and say they will assist her shortly, but do not come back to provide the needed care. She stated that she often attempts to change and clean herself, even though she understands it is unsafe for her to ambulate without staff assistance. She explained that it bothers her when she is dirty from soiling her brief. Resident 18 also stated that if she wants a shower after soiling herself, staff tells her that she can only take a shower on her scheduled shower days twice a week. Resident 18 stated that she often asks for clean linens for her bed but staff tell her that she is only allowed clean linens on her shower days twice a week. She explained that she would change the sheets herself, but staff refused to provide her clean bed linens. Resident 18 also stated that sometimes nursing staff send the residents to common areas or programs without helping them get dressed. She stated that she was sent to the dining room in her nightgown, and that these experiences make her feel terrible.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the resident group interview, Resident 24 expressed that she is upset when staff tells her that she is not allowed to ring her call bell for assistance when meals are being passed out at breakfast, lunch, or dinner. She explained that the staff tell her that she needs to go to the bathroom before the meal or wait until after meal service. She stated that she sometimes must sit in her urine or feces while she waits for staff assistance. Resident 24 expressed that it makes her angry because she is over [AGE] years old and can't hold it when she needs to use the bathroom. She stated that she is not sure how long it takes for staff to respond, but often longer than her body could wait. Resident 24 stated that she has been taking herself to the bathroom, even though she knows it is unsafe for her to do so.</p> <p>During the group interview, Resident 37 stated that she is upset that she waits 15-20 minutes for staff to respond to her call bell when she needs assistance. She explained that nursing staff will initially respond, turn her call bell off, but leave without providing her care. She stated that she would holler and yell until someone responds. Resident 37 said it bothers her when she must wait 15 minutes for staff when seated on the toilet because it hurts to sit so long.</p> <p>During the group interview, Resident 41 stated that she often waits 45 minutes for care from staff when needed. She explained that she is on a medication that causes her to frequently urinate and often needs her brief changed. Resident 41 stated that she often sits in a urine puddle, waiting for staff assistance. She explained that if she needs to be changed in the morning, staff will tell her after breakfast and tell her you need to wait. Resident 41 indicated that it upsets her because she does not want to sit in her urine.</p> <p>During the group interview, Resident 51 stated that she waits 45 minutes to an hour for care from staff when needed. She explained that after 15 or 20 minutes of waiting for staff to respond to her call bell ring for assistance, she will use her cell phone to call the nursing station or the front desk. Also, she stated that staff will call her cellphone instead of physically checking on her when she rings her call bell for assistance.</p> <p>During the group interview, Resident 83 stated that he tries to care for himself as much as possible. He explained that last week staff did not respond to his call-bell for assistance, and he had to use his cell phone to get staff to bring him a cup of water. Resident 83 stated that it took him an hour to get a drink of water.</p> <p>During the group interview, Resident 107 stated that she waits a long time to receive care after ringing her bell for assistance. She explained that she waits 15 minutes or longer for care. Resident 107 expressed that she is upset when she is not allowed to have a shower, and nursing staff tell her she can only shower on her scheduled days twice a week. She stated that she enjoys feeling clean and wants to be able to shower more often than twice a week.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the group interview, Resident 114 stated on several recent occasions, she has waited over an hour for care after ringing her call bell for assistance. She expressed anger and frustration that she has to sit in her soiled brief because she does not have the ability to clean herself. Resident 114 stated that she had loose stools and had to sit in the dirty brief for 45 minutes. She explained that sometimes she will ring for assistance, and staff will walk right past her door without looking or saying a word to her. Resident 114 expressed frustration that staff refuse to change her during meal times, forcing her to remain in a soiled brief until the meal service is over. Resident 114 also expressed being upset when staff tell her during the early afternoon that if we change you now, then you have to stay in bed the rest of the day. She is angry and frustrated because she can't control when she soils herself and needs staff assistance with care.</p> <p>During an interview on June 14, 2024, at approximately 11:00 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) verified that all residents at the facility should be treated with dignity and respect. The NHA and DON were unable to explain why residents are reporting (1) untimely staff responses to residents' requests for assistance, (2) staff refusing to shower residents at their desired frequency, (3) staff refusing to provide residents with clean linens, and (4) residents being told not to ring their call bells during meals, which is negatively affecting their quality of life in the facility.</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 201.29 (a) Resident Rights</p> <p>28 Pa. Code 211.12 (c) Nursing services</p>

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>48276</p> <p>Based on observation, a review of clinical records and select facility policy, staff and resident interviews, it was determined that the facility failed to ensure the self-administration of medications was clinically appropriate for one of the 27 residents sampled (Resident 7).</p> <p>Findings include:</p> <p>A review of facility policy titled Self-Administration of Medications, provided by the facility on April 18, 2024, indicated residents have the right to self-administer medications if the interdisciplinary team has determined that is clinically appropriate and safe for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and care plan.</p> <p>A clinical record review revealed Resident 7 was admitted to the hospital on October 14, 2022, with diagnoses that include acute respiratory failure (a condition where the respiratory system is unable to remove carbon dioxide from or provide oxygen to the body) and chronic kidney disease (gradual loss of kidney function).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 29, 2024, revealed that Resident 7 is cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</p> <p>During an interview and observation on June 11, 2024, at 12:00 PM, Resident 7 was observed seated by her bed. On her bedside table were five pills in a small, clear plastic cup. The resident stated that she is unable to swallow them all at once, so the nurses leave the pills by her table, and she takes the medications one at a time as she is able.</p> <p>During an interview on June 11, 2024, at 12:08 PM, Employee 11, Licensed Practical Nurse (LPN), confirmed that she left the pills with Resident 7 because the resident was unable to swallow them all at once. Employee 11, LPN, was unable to confirm if Resident 7 was assessed or approved to safely self-administer medication.</p> <p>An authorization of self-administration of drugs {medications} form, with no date indicated, revealed that Resident 7 elected not to exercise her right to self-administer medications.</p> <p>A clinical record review failed to find documented evidence that Resident 7 was assessed and deemed safe and appropriate to self-administer her medications.</p> <p>During an interview on June 14, 2024, at approximately 11:00 AM, the Director of Nursing (DON) confirmed that there was no documented evidence that Resident 7 was assessed and deemed safe and clinically appropriate to self-administer her medications. The DON confirmed that without an assessment, Resident 7 should not have been allowed to self-administer her medications.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa Code: 211.9 (a)(1) Pharmacy services.</p> <p>28 Pa Code 211.10 (c)(d) Resident care policies.</p> <p>28 Pa Code 211.12 (d)(1)(5) Nursing services.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>21738</p> <p>Based on review of select facility incident reports and staff and resident interview, it was determined that the facility failed to ensure that mail was delivered unopened to one of 11 residents interviewed during a resident group interview (Resident 106).</p> <p>Findings include:</p> <p>Definitions under the regulatory guidance for S483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>During a resident group interview on June 12, 2024, at 11:40 AM, Resident 106 stated that he does not receive his incoming mail and packages unopened. Resident 106 stated in the past there was a mix-up with prescription medication arriving in a package from a healthcare facility addressed to him instead of being sent directly to the facility.</p> <p>Review of a facility incident report dated May 21, 2024, Resident 106 was found with Buprenorphine patches (opioid analgesic, controlled substance) in his room. The patches arrived in a package from a local healthcare clinic where Resident 106 was seen for an appointment. The local healthcare clinic was contacted to address the mistake of sending medication directly to Resident 106 while a resident at the facility. A procedure was put in place that any future packages from the healthcare clinic would be addressed to the care of nursing supervisor for Resident 106.</p> <p>To avoid similar incidents staff who receive Resident 106's were inserviced on May 29, 2024, to identify and record any packages which arrive for Resident 106 which are addressed care of nursing supervisor and alert the nursing supervisor upon receiving any such packages.</p> <p>Interview with the director of nursing (DON) on June 13, 2024, at 1:30 PM confirmed that any packages which were received care of nursing supervisor for Resident 106 should still be opened by the resident with the nursing supervisor present. The DON confirmed that there have been no further incidents of Resident 106 receiving packages addressed care of the nursing supervisor. The DON confirmed that Resident 106's mail or packages should not be opened by staff. The DON confirmed that all residents including Resident 106 have the right to receive mail and packages unopened.</p> <p>28 Pa. Code 201.29(a) Resident rights.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on a review of clinical records, select facility policy and investigative reports, and staff interviews, it was determined that the facility failed to ensure that four residents out of 30 sampled were free from physical abuse (Residents 62, 85, 97, and 119).</p> <p>Findings include:</p> <p>A facility policy titled Abuse Prevention Program, reviewed on April 18, 2024, revealed it is facility policy that residents have the right to be free from abuse, including physical abuse. Further policy review revealed that the administration will implement protocols to protect residents from abuse by anyone, including other residents.</p> <p>A clinical record review revealed Resident 62 was admitted to the facility on [DATE] with diagnoses that include dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 2, 2024, revealed that Resident 62 is severely cognitively impaired with a BIMS score of 3 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 01-07 indicates severe cognitive impairment).</p> <p>A clinical record review revealed Resident 85 was admitted to the facility on [DATE], with diagnoses that include dementia. A review of quarterly, MDS dated [DATE], Section C - Cognitive Patterns, C1000, revealed that Resident 85 has severe impairment to make decisions regarding tasks of daily life. The MDS indicates that a BIMS assessment should not be completed because the resident is rarely or never understood.</p> <p>A clinical record review revealed that Resident 97 was admitted to the facility on [DATE], with diagnoses that include alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). and dementia.</p> <p>A review of a quarterly MDS dated [DATE] revealed that Resident 97 is severely cognitively impaired with a BIMS score of 3 (a score of 01-07 indicates severe impairment).</p> <p>A plan of care indicating that Resident 97 has a behavior problem related to dementia with episodes of agitation, confusion, aggressive episodes, and physical aggression was initiated on March 16, 2023, with revisions on October 19, 2023. Interventions include administering medication as ordered, providing positive interactions, anticipating and meeting the resident's needs, decreasing the overstimulating environment by walking with the resident to a calmer area, attempting to engage the resident in conversation or activity involving cars, avoiding violent movies or shows, offering a program of activities of interest, providing quiet space, and redirection.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A clinical record review revealed Resident 119 was admitted to the facility on [DATE], with diagnoses that include alzheimer's disease and dementia. A review of admission MDS dated [DATE] revealed that Resident 119 is severely cognitively impaired with a BIMS score of 3 (a score of 01-07 indicates severe impairment).</p> <p>A review of incident and investigation reports revealed Resident 97 elbowed Resident 62 in the chest on February 19, 2024.</p> <p>A review of incident and investigation reports revealed Resident 97 pushed Resident 85, causing her to fall to the floor on April 2, 2024.</p> <p>A review of incident and investigation reports revealed Resident 97 hit Resident 62 in the back of the head and Resident 62 hit Resident 97's right arm on May 26, 2024.</p> <p>A review of incident and investigation reports revealed Resident 97 hit Resident 119's head twice with a closed fist on June 9, 2024.</p> <p>A witness statement dated February 19, 2024, indicated that Employee 6, Nurse Aide, witnessed Resident 97 elbow Resident 62 in his chest. Employee 6, Nurse Aide, explained that she yelled for help, and staff were able to separate the residents.</p> <p>A nursing note dated February 19, 2024, at 5:42 PM indicated that a Registered Nurse assessment was completed and Resident 62 had no injuries.</p> <p>A nursing note dated February 19, 2024, at 5:49 PM indicated that a Registered Nurse assessment was completed and Resident 97 had no injuries.</p> <p>A social services progress note dated February 20, 2024, at 2:05 PM revealed that Resident 97 had no recollection of the incident, and no ill effects were noted. The entry noted that Resident 97 denied concerns and complaints and responded well to support and encouragement.</p> <p>A social services progress note dated February 20, 2024, at 2:08 PM revealed that Resident 119 was pleasantly confused, had no recollection of the event, and presented no signs or symptoms of distress. Resident 119 denied concerns and complaints and responded well to support and encouragement.</p> <p>A witness statement dated April 2, 2024, indicated that Employee 7, Nurse Aide, was in the dining room and saw Resident 97 push Resident 85, causing the resident to lose her balance and fall to the floor.</p> <p>A clinical record review revealed no evidence that Resident 85 was assessed for injury on April 2, 2024, after Resident 97 pushed the resident to the floor.</p> <p>A social services note dated April 3, 2024, at 1:10 PM indicated that Resident 85 was seen following the incident during which Resident 97 pushed Resident 85 to the floor. The note indicated that Resident 85 was pleasant throughout the conversation, smiling appropriately, and had no recollection of the incident. The resident appeared with no signs or symptoms of acute distress or discomfort.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A social services note dated April 3, 2024, at 1:10 PM indicated that Resident 97 reported that he had no recollection of the event, no concerns or complaints regarding his peer, and appeared with no signs or symptoms of acute distress or discomfort.</p> <p>A witness statement dated May 26, 2024, indicated Employee 8, Nurse Aide, was in the activity room when Resident 97 got up and smacked Resident 62 on the back of the head.</p> <p>A witness statement dated May 26, 2024, indicated that Employee 9, Nurse Aide, was in the dining room when Resident 97 stood up and aggressively smacked Resident 62 in the back of his head. Resident 62 then smacked Resident 97 on the arm. Nurse Aide, indicated he intervened and separated the residents.</p> <p>A progress note dated May 26, 2024, at 5:36 PM revealed that Resident 97 was assessed with no injuries noted.</p> <p>A progress note dated May 26, 2024, at 5:40 PM revealed that Resident 62 was assessed with no injuries noted.</p> <p>An incident note dated June 9, 2024, at 12:30 PM indicated Resident 119 was struck by another resident in the dayroom. The note indicated that the resident had no apparent injuries and denied pain.</p> <p>A witness statement, dated June 9, 2024, revealed that Employee 10, Licensed Practical Nurse, received a report that Residents 97 and 119 were arguing when Resident 97 punched Resident 119. Residents were separated and assessed for injuries.</p> <p>A witness statement dated June 9, 2024, revealed that Visitor 1 was in the activity room visiting with her mom when she saw Resident 97 yell at Resident 119 and hit him in the head. She indicated that she went to get help.</p> <p>A witness statement dated June 9, 2024, revealed that Visitor 2 witnessed Resident 97 hit Resident 119.</p> <p>A social service note, dated June 11, 2024, at 9:02 AM, indicated Resident 97 had no issues or concerns and was offered support.</p> <p>A social service note, dated June 11, 2024, at 9:05 AM, indicated Resident 119 had no issues or concerns and was offered support.</p> <p>During an interview on June 14, 2024, at approximately 11:00 AM, the DON (director of nursing) and NHA (nursing home administrator) confirmed the facility failed to protect the above residents from physical abuse perpetrated by other residents. The DON and NHA confirmed that residents have the right to be free from abuse, including physical abuse perpetrated by other residents.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29(a) Resident Rights</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on a clinical record review and staff interview, it was determined that the facility failed to ensure that the necessary resident information was communicated to the receiving health care provider for one resident out of 27 residents sampled with facility-initiated transfers (Residents 7).</p> <p>Findings include:</p> <p>A clinical record review revealed that Resident 7 was transferred to a community hospital on June 8, 2024, and returned to the facility on [DATE].</p> <p>A nursing progress note dated June 8, 2024, at 2:09 PM indicated that Resident 7 was sent to the receiving provider and sent with all appropriate paperwork. There was no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, including contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, advance directive information, all special instructions or precautions for ongoing care, as appropriate, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>During an interview on June 14, 2024, at approximately 11:30 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider for Resident 7's facility-initiated transfers on June 8, 2024.</p> <p>28 Pa. Code 201.29 (a)(c.3)(2) Resident rights</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p>		

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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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on review of clinical records and transfer notices, and staff interviews, it was determined that the facility failed to provide written notices of facility-initiated transfers to the resident and the resident's representative for eight out of the 27 residents reviewed (Residents 7, 114, 101, 9, 63, 112, 2, and 106).</p> <p>Findings include:</p> <p>A clinical record review revealed that Resident 114 was transferred to the hospital on March 11, 2024, and returned to the facility on [DATE].</p> <p>A clinical record review revealed no documented evidence that a notice of transfer or discharge letter was provided to Resident 114 and her resident representative regarding her transfer to the hospital on March 11, 2024, or as soon as practical.</p> <p>A clinical record review revealed that Resident 7 was transferred to the hospital on June 8, 2024, and returned to the facility on [DATE].</p> <p>A clinical record review revealed no documented evidence that a notice of transfer or discharge letter was provided to Resident 7 and her resident representative regarding her transfer to the hospital on June 8, 2024.</p> <p>A clinical record review revealed that Resident 101 was transferred to the hospital on March 3, 2024, and returned March 15, 2024. The resident was again transferred to the hospital on March 30, 2024 and returned April 2, 2024.</p> <p>Clinical record review revealed no documented evidence that a notice of transfer or discharge letter was provided to Resident 101 and his resident representative regarding his transfer to the hospital on March 3 and March 30, 2024.</p> <p>A clinical record review revealed that Resident 9 was transferred to the hospital on May 15, 2024, and returned to the facility on [DATE].</p> <p>A clinical record review revealed no documented evidence that a notice of transfer or discharge letter was provided to Resident 9 and her resident representative regarding her transfer to the hospital on May 15, 2024.</p> <p>A clinical record review revealed that Resident 63 was transferred to a community hospital on December 5, 2023, and returned December 7, 2023. The resident was again transferred to the hospital on January 5, 2024, and returned January 9, 2024.</p> <p>Clinical record review revealed no documented evidence that a notice of transfer or discharge letter was provided to Resident 63 and his resident representative regarding his transfer to the hospital on December 5, 2023, and January 5, 2024.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>A clinical record review revealed that Resident 112 was transferred to the hospital on December 22, 2023, and returned December 28, 2023, on January 2, 2024, and returned January 4, 2024, February 19, 2024, and returned on February 27, 2024, March 6, 2024, and returned March 11, 2024, and on March 21, 2024, and returned on March 25, 2024. The resident was again transferred to the hospital on May 20, 2024, and returned May 24, 2024.</p> <p>Clinical record review revealed no documented evidence that a notice of transfer or discharge letter was provided to Resident 112 and his resident representative regarding his transfer to the hospital on December 22, 2023, January 2, 2024, February 19, 2024, March 6, 2024, March 21, 2024, and May 20, 2024.</p> <p>A clinical record review revealed that Resident 2 was transferred to a community hospital on March 28, 2024, and readmitted to the facility as a new admission on May 24, 2024, after a stay in a specialty hospital unit.</p> <p>Clinical record review revealed no documented evidence that a notice of transfer or discharge letter was provided to Resident 2 and his resident representative regarding his transfer to the hospital on March 28, 2024.</p> <p>A clinical record review revealed that Resident 106 was transferred to the hospital on May 3, 2024, and readmitted to the facility on [DATE].</p> <p>Clinical record review revealed no documented evidence that a notice of transfer or discharge letter was provided to Resident 106 and his resident representative regarding his transfer to the hospital on May 11, 2024.</p> <p>During an interview on June 14, 2024, at approximately 11:30 AM, the Nursing Home Administrator and Director of Nursing confirmed that the facility had no documented evidence that Residents 7, 14, 101, 9, 63, 112, 2, and 106 and their representatives were provided written notices for the facility-initiated transfers.</p> <p>28 Pa. Code 201.29 (a)(c.3)(2) Resident rights</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on a review of clinical records and select facility policy, staff, and resident interviews, it was determined the facility failed to provide written notice of the facility's bed hold policy to a resident and the resident's representative upon the resident's transfer to the hospital for eight residents out of the 27 sampled (Residents 7, 114, 101, 9, 63, 112, 2, and 106).</p> <p>Findings include:</p> <p>A review of facility policy titled Bed-Holds and Returns, last reviewed on April 18, 2024, revealed it is the facility's policy to inform all residents and/or resident representatives in writing of the facility and state bed-hold policies. The policy indicates that all residents and resident representatives, regardless of payor source, are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence at least twice: (1) on admission and (2) at the time of transfer (if the transfer was an emergency, within 24 hours).</p> <p>A clinical record review revealed that Resident 114 was transferred to the hospital on March 11, 2024, and returned to the facility on [DATE].</p> <p>A clinical record review revealed no documentation that Resident 114 was made aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital.</p> <p>During an interview on June 11, 2024, at 10:45 AM, Resident 114 stated that she didn't know she was going to lose her room and was very upset when she returned to the facility and was placed in a new room. She stated that she was never provided any written or verbal notification when she was transferred to the hospital. Resident 114 explained that she learned that she lost her room upon return to the facility, which was five days after transfer to the hospital.</p> <p>A clinical record review revealed that Resident 7 was transferred to the hospital on June 8, 2024, and returned to the facility on [DATE].</p> <p>A nursing progress note dated June 8, 2024, at 2:09 PM indicated that Resident 7 was sent to the receiving provider and sent with all appropriate paperwork.</p> <p>Further review revealed no documentation that Resident 7 was made aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital.</p> <p>A clinical record review revealed that Resident 101 was transferred to the hospital on March 3, 2024, and returned March 15, 2024. The resident was again transferred to the hospital on March 30, 2024 and returned April 2, 2024.</p> <p>Further review revealed no documentation that Resident 101 was made aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital on March 3, 2024 or March 30, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A clinical record review revealed that Resident 63 was transferred to the hospital on December 5, 2023, and returned December 7, 2023. The resident was again transferred to the hospital on January 5, 2024, and returned January 9, 2024.</p> <p>Further review revealed no documentation that Resident 63 was made aware of a facility's bed-hold and reserve bed payment policy upon transfer to a community hospital on December 5, 2023 or January 5, 2024.</p> <p>A clinical record review revealed that Resident 112 was transferred to the hospital on December 22, 2023, and returned December 28, 2023, on January 2, 2024, and returned January 4, 2024, on February 19, 2024, and returned on February 27, 2024, on March 6, 2024, and returned March 11, 2024, and on March 21, 2024, and returned on March 25, 2024. The resident was again transferred to the hospital on May 20, 2024, and returned May 24, 2024.</p> <p>Further review revealed no documentation that Resident 112 was made aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital on December 22, 2023, January 2, 2024, February 19, 2024, March 6, 2024, March 21, 2024, and May 20, 2024.</p> <p>A clinical record review revealed that Resident 2 was transferred to the hospital on March 28, 2024, and returned May 24, 2024.</p> <p>Further review revealed no documentation that Resident 2 was made aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital on March 28, 2024.</p> <p>A clinical record review revealed that Resident 106 was transferred to the hospital on May 3, 2024, and returned May 11, 2024.</p> <p>Further review revealed no documentation that Resident 106 was made aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital on May 3, 2024.</p> <p>During an interview on June 14, 2024, at approximately 11:30 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were unable to provide evidence that the facility made Residents 7, 114, 101, 63, 112, 2, and 106 or the residents' representatives aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital.</p> <p>28 Pa Code 201.18 (e)(1) Management</p> <p>28 Pa Code 201.29 (b) Resident rights</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on a review of the Resident Assessment Instrument Manual and clinical records, and staff interview, it was determined that the facility failed to timely submit Minimum Data Set (MDS) assessments to the required electronic system, the CMS Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, for one of eight sampled (Resident 72).</p> <p>Findings Include:</p> <p>The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, which provides instructions and guidelines for completing the Minimum Data Set (MDS) dated [DATE], requires that discharge assessments-return anticipated (non-comprehensive) be completed no longer than the resident's discharge date + 14 calendar days.</p> <p>A clinical record review revealed that Resident 72 was transferred to the hospital on April 30, 2024.</p> <p>A progress note dated May 3, 2024, revealed that Resident 72 returned to the facility.</p> <p>Further review of the clinical record revealed no documented evidence that an MDS discharge assessment-return anticipated (non-comprehensive) was completed for Resident 72.</p> <p>During an interview on June 13, 2024, at approximately 1:00 PM, the director of nursing confirmed that Resident 72's discharge return anticipated MDS assessment was not completed and submitted within the required timeframes.</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** 39235</p> <p>Based on observation, review of clinical records, and staff interview it was determined that the facility failed to address a resident's active diagnoses and treatment and individualized communication methods and needs on the resident's care plan for one resident out of 27 sampled (Resident 112).</p> <p>Findings included:</p> <p>A review of Resident 112's clinical record revealed he was admitted to the facility on [DATE], with diagnosis to include diabetes, Parkinson's disease (a long-term neurodegenerative disease of mainly the central nervous system), and peripheral vascular disease (a slow, and progressive disorder of the blood vessels - PVD).</p> <p>A review of the admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated December 5, 2023, revealed that the resident is Hispanic, Latino/a, or Spanish in origin, and that Resident 112's preferred language is Spanish (Español and) and that the resident does need - wants an interpreter to communicate with a doctor or health care staff.</p> <p>A review of Resident 112's clinical record, Social Determinants of Health notes dated November 30, and December 28, 2023, and March 27, 2024, stating the resident is Hispanic, Latino/a, or Spanish in origin, and his language is Spanish. The resident does need -want an interpreter to communicate.</p> <p>A nurses note dated January 2, 2024, at 1655 (4:55 PM) indicated that a language barrier was noted as the resident does not speak English. A CNA (certified nursing assistant) was present, speaks Spanish and was assisting with translation.</p> <p>An observation on June 11, 2024, at approximately 11:10 AM, revealed no visible communication tool, such as a communication board or translation device available to aid the resident in communication with others.</p> <p>A second observation and attempted interview with Resident 112's, in his room on June 11, 2024, at approximately 11:55 AM, upon entering the room, the alert resident sat up in his bed and smiled. In the presence of Employee 1, nurse aide (NA), the observation of the residents room to include his wardrobe, dresser, nightstand, and wheelchair revealed no visible communication device, board, tablet, or picture book, was available to aid communication with the resident.</p> <p>At this time, Employee 2, Licensed Practical Nurse (LPN), confirmed the observation, and stated the facility utilizes the services of a phone interpreter. However, the observation of Resident 112's room failed to reveal the contact information for the interpreter, phone number, and or directions to access the service.</p> <p>(continued on next page)</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>A review of Resident 112's care plan in effect during the survey ending June 14, 2024, indicated the residents admitted was November 29, 2023, and revealed that the resident's comprehensive care plan did not include the resident's known conditions to include Parkinson's disease, PVD, nor his preferred language, and or any assistive devices to be used in an attempt to communicate with Resident 112.</p> <p>During an interview with the Director of Nursing (DON) on June 12, 2024, at approximately 9:10 AM, confirmed facility failed to fully develop and implement person-centered comprehensive care plan in a manner that assures staff are aware of the resident's specific and individualized interventions to address a resident's health needs, including communication methods.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 21738</p> <p>Based on review of select facility policy and clinical records and staff interview, it was determined that the facility failed to provide restorative nursing services planned to maintain mobility and functional abilities of four of 27 residents sampled (Residents 63, 114, 72, and 2).</p> <p>Findings included:</p> <p>A review of facility policy titled Restorative Nursing Services, last reviewed by the facility on April 18, 2024, revealed that it is the facility policy that residents will receive restorative nursing care as needed to help promote optimal safety and independence. The policy indicates restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care.</p> <p>A review of the clinical record of Resident 63 revealed admission to the facility on [DATE], with diagnoses to include cerebrovascular disease (stroke), hemiplegia (one sided paralysis - weakness) and hemiparesis (one sided weakness) following cerebral infarction affecting left non-dominant side, muscle weakness, difficulty in walking, muscle wasting and atrophy, and lack of coordination.</p> <p>A review of Resident 63's Occupational Therapy (OT) Discharge Summary dated September 20, 2023, indicated that the resident was receiving OT services from September 14, 2023, to September 20, 2023, and that the discharge recommendations were to receive restorative range of motion program.</p> <p>A Rehab Discharge Recommendation form: Occupational Therapy dated September 20, 2023, indicated that the resident was to receive restorative services, active range of motion (AROM)/active assist range of motion (AAROM)/passive range of motion (PROM), of bilateral upper extremity (BUE) and bilateral lower extremity (BLE) as tolerated.</p> <p>During an interview on June 13, 2024, at approximately 9:10 AM, with the Director of Therapy Services, confirmed Resident 63 should have received restorative range of motion program, from September 20, 2023, to the present.</p> <p>A review of the resident's clinical record to include the Documentation Survey Report v2 from September 2023, through the survey ending June 14, 2024, revealed that Resident 63's restorative range of motion program was not implemented, as recommended by the OT discharge summary, and the Rehab Discharge Recommendation form: Occupational Therapy.</p> <p>Interview with the Director of Nursing (DON) on June 13, 2024, at approximately 9:30 AM failed to provide documented evidence that Resident 63 was provided with the restorative range of motion program.</p> <p>A clinical record review revealed that Resident 114 was admitted to the facility on [DATE], with diagnoses to include cauda equina syndrome (a condition that occurs when the nerve roots in the lumbar spine are compressed, cutting off sensation and movement).</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a quarterly Minimum Data Set assessment dated [DATE] revealed that Resident 114 is cognitively intact with a BIMS score of 15.</p> <p>A physical therapy discharge summary dated March 8, 2024, revealed that Resident 114's functional status at discharge was given to the restorative nursing program coordinator.</p> <p>A physical therapy rehab discharge recommendation form, dated March 10, 2024, indicated that the resident would benefit from active and passive lower extremity range of motion and strengthening while in bed and while seated on the resident's hips, knees, and ankles.</p> <p>Resident 114's care plan noted the problem of impaired physical mobility and lower extremity weakness related to Caude Equina syndrome initiated on February 8, 2024. There was no documented evidence that recommendations for active range of motion or passive range of motion exercise interventions were incorporated into Resident 114's plan of care.</p> <p>A certified registered nurse practitioner note dated April 9, 2024, at 2:47 PM indicated that Resident 114 should be on restorative therapy while not on physical therapy for strengthening to not lose muscle tone.</p> <p>During an interview on June 11, 2024, at 10:45 AM Resident 114 stated that her therapy services ended in March 2024. She explained that she spoke with therapy staff and nursing staff about her interest in participating in restorative nursing services on several occasions. She indicated that staff do not provide her with active or passive exercises. She indicated that she had a meeting last month specifically to address this issue; however, no services were implemented. Resident 114 stated that it is very important for her to participate in any program that would assist her in her physical recovery.</p> <p>During an interview on June 14, 2024, at approximately 11:00 AM, the Director of Nursing (DON) confirmed that Resident 114's care plan was not updated to include physical therapy restorative program recommendations for active range of motion and passive range of motion exercise interventions. The DON was unable to provide evidence that Resident 114 was receiving active range of motion exercises while seated and while in bed for her hips, knees, or ankles, consistent with physical therapy recommendations and the resident's individual goals.</p> <p>A review of the clinical record of Resident 72 revealed admission to the facility on [DATE], with diagnoses to include poliomyelitis (polio- illness caused by a virus that mainly affects nerves in the spinal cord or brain stem).</p> <p>A review of Resident 72's Physical Therapy Discharge Summary dated February 22, 2024, indicated that the resident was receiving services from February 8, 2024, to February 22, 2024, and that the discharge recommendations were to receive restorative range of motion program.</p> <p>During an interview on June 13, 2024, at approximately 9:30 AM, with the Director of Therapy Services, confirmed Resident 72 should have received restorative range of motion program upon conclusion of physical therapy on February 22, 2024.</p> <p>Further review of the clinical record revealed no documented evidence that a restorative range of motion program was implemented for Resident 72.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Director of Nursing (DON) on June 13, 2024, at approximately 9:45 AM failed to provide documented evidence that Resident 72 was provided with the restorative range of motion program.</p> <p>A review of the clinical record of Resident 2 revealed the resident was admitted to the facility on [DATE], with diagnoses to include cerebral palsy (group of conditions that affect movement and posture caused by damage to the developing brain most often before birth).</p> <p>A review of Resident 2's Rehab Discharge Recommendation from Physical Therapy dated May 28, 2024, indicated that the resident was recommended for restorative lower extremity range of motion/strengthening.</p> <p>Further review of the clinical record revealed no documented evidence that a restorative range of motion program was implemented for Resident 2.</p> <p>Interview with the Director of Nursing (DON) on June 13, 2024, at approximately 9:45 AM failed to provide documented evidence that Resident 2 was provided with the restorative range of motion program.</p> <p>28 Pa. Code: 211.5(f) Medical records</p> <p>28 Pa. Code: 211.12(c)(d)(3)(5) Nursing services</p> <p>28 Pa. Code 211.10 (a)(c)(d) Resident care policies</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235</p> <p>Based on review of clinical records, and staff interviews, it was determined that the facility failed to thoroughly assess and evaluate bladder function and implement individualized interventions to restore bladder function to the extent possible for one resident (Residents 47), and provide care and services to prevent potential complications with the use of an indwelling foley catheter (a flexible tube which is placed into the bladder to drain urine) for one resident out of two sampled with a foley catheter (Resident 101).</p> <p>Findings include:</p> <p>Department of Health & Human Services, USA. Centers for Disease Control and Prevention, Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009, last updated June 6, 2019, III Proper Techniques for Urinary Catheter Maintenance, B. Maintain unobstructed urine flow. 2. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor.</p> <p>Review of Resident 47's clinical record revealed admission to the facility on [DATE], with diagnoses that included Parkinson's disease (a long-term neurodegenerative disease of mainly the central nervous system), diabetes, and hypertension.</p> <p>A review of the residents Quarterly Minimum Data Set Assessments (MDS - a federally mandated standardized assessment completed at specific intervals to define resident care needs) dated May 12, 2023, Annual MDS dated [DATE], and Quarterly MDS dated [DATE], Section H Bladder and Bowel, all indicated the resident was coded a (2) indicating frequently incontinent of bladder.</p> <p>Resident 47's Quarterly MDSs dated February 12, 2024, and May 14, 2024, Section H Bladder and Bowel, noted that the resident was always incontinent of bladder (a decline of urinary bladder function).</p> <p>The resident's plan of care for bladder incontinence, date-initiated August 16, 2022, revealed planned measures included to check the resident per protocol and as required for incontinence, monitor/document for sign/symptoms of UTI, urinary frequency, change in behavior, and preventative skin care per protocol.</p> <p>During an interview with the Director of Nursing (DON) on June 12, 2024, at approximately 1:50 PM, it was confirmed that there was no documented evidence that the facility had recognized the increased urinary incontinence and completed incontinence evaluations or implemented any scheduled toileting programs in response to the resident's decline in bladder function.</p> <p>A review of Resident 101's clinical record revealed admission to the facility on [DATE], with diagnosis to include benign prostatic hyperplasia (BPH- age-associated prostate gland enlargement that can cause urination difficulty) with lower urinary tract symptoms, retention of urine, and Alzheimer's disease.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER River View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1555 East End Boulevard Plains Twp Wilkes Barre, PA 18711	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident had a physician order, initially dated May 22, 2024, for a foley catheter (a flexible tube inserted through the urinary opening (urethra) and into the bladder. The device drains the urine into a drainage bag).</p> <p>Observation of Resident 101 in the resident's room on June 11, 2024, at 10:40 AM revealed that the resident was lying in bed with the bed lowered close to the floor. The resident's urinary collection bag, which was attached to the base of the bedframe, was directly in contact with the floor without a barrier or additional protective covering.</p> <p>Further observation of Resident 101, accompanied by Employee 5 (Licensed Practical Nurse), in the resident's room, on June 13, 2024, at 9:48 AM, revealed that the resident's bed was in a low position with the urinary collection bag directly in contact with the floor and without a barrier or protective covering.</p> <p>Interview with Employee 5, on June 13, 2024, at 9:50 AM confirmed that the collection bag should not have been directly in contact with the floor to prevent urinary tract infection.</p> <p>Interview with the Director of Nursing (DON) on June 14, 2024, at approximately 11:00 AM confirmed that the facility failed to maintain Resident 101's foley catheter in a manner to prevent potential infection.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p> <p>28 Pa. Code 211.10 (a)(d) Resident care policies</p>		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to failed to timely implement a nutritional support regimen to meet the nutritional needs and prevent weight loss for one resident (Resident 90) and failed to accurately monitor a fluid restriction prescribed to address a resident's clinical condition and maintain fluid balance and adequate hydration status for one resident (Resident 178) out of 27 sampled.</p> <p>Findings include:</p> <p>A review of a facility policy Weight Assessment and Intervention last reviewed by the facility April 18, 2024, indicated that resident weights are monitored for undesirable or unintended weight loss or gain. Residents are weighed upon admission, weekly x 4 weeks, and then monthly or per physician orders. If the weight loss is 5-pound difference from the last weight, a re-weight will be obtained and validated. The dietician will review the weight record to follow individual weight trends. The threshold for significant unplanned and undesired weight loss is based on the following criteria:</p> <p>a. 1 month - 5% weight loss is significant; greater than 5% is severe.</p> <p>b. 6 months - 10% weight loss is significant; greater than 10% is severe.</p> <p>The policy further indicated that undesirable weight change is evaluated by the physician and dietitian. The physician and multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss.</p> <p>Review of Resident 90's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to include osteomyelitis (inflammation of the bone caused by an infection), muscle wasting and atrophy.</p> <p>A review of Resident 90's care plan, initiated May 23, 2024, identified that the resident may be nutritionally at risk related to diet restrictions, obesity, weight loss and variable PO intake, and skin integrity. The resident's goal was to consume at least 50% of at least 2 meals daily and maintain weight within 3% of CBW (current body weight). Planned interventions included to assist with meals as needed, monitor/document/report refusals to eat, and for the registered dietitian to make diet change recommendations as needed.</p> <p>Review of Resident 90's resident's weight record revealed:</p> <p>May 22, 2024 160.2 pounds</p> <p>May 29, 2024 157.8 pounds</p> <p>June 6, 2024 149.2 pounds - 6.87% significant weight loss</p> <p>(continued on next page)</p>		

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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>There was no evidence of a re-weight being obtained to confirm Resident 90's significant weight loss as per facility policy There was no evidence that facility notified Resident 90's physician of the 6.87% significant weight loss in one week.</p> <p>A review of the resident's survey documentation report (a computer-generated report that records the data that nurse aides enter for meal consumption and other care tasks performed) dated June 2024, revealed that from June 1, 2024, through June 13, 2024, Resident 90 refused 8 meals out of 37 served meals, consumed 25% or less for 8 meals, and consumed 50% or less for 9 meals. Resident's consumption of 51% to 100% of meals occurred only 12 times out of 37 meals served.</p> <p>Observation on June 12, 2024, at 7:50 AM, revealed Resident 90 in bed, positioned upright, asleep. Her breakfast tray was positioned in front of her, untouched. Resident 90 was observed to be alone with no staff present to provide assistance.</p> <p>There was no indication that the facility identified and acted upon Resident 90's weight loss and had determined if nutritional support interventions were necessary to prevent further weight loss. There also was no indication that the physician, and resident representative were informed of the significant weight loss.</p> <p>The facility failed to identify Resident 90's weight loss, failed to identify and act upon her decreased meal intakes, failed to provide feeding assistance as needed as indicated in her plan of care, and failed to implement nutritional support to prevent further weight loss. There was also no evidence that the facility had notified the resident's attending physician and resident representative of the significant weight loss.</p> <p>Interview with the Director of Nursing on June 14, 2024, at 8:30 AM, confirmed that the facility failed to timely identify, address, and implement weight loss interventions to improve Resident 90's nutritional status.</p> <p>Clinical record review revealed that Resident 178 was admitted to the facility on [DATE], with diagnoses which included congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should).</p> <p>A physician order dated June 6, 2024, was noted for a 1500 cc fluid restriction.</p> <p>Review of Resident 178's lunch meal tag on June 11, 2024, revealed no evidence that the resident was on a fluid restriction.</p> <p>Further review of the clinical record revealed no documented evidence that the physician prescribed fluid restriction was implemented to ensure that the resident did not exceed 1500 cc's of fluid per day.</p> <p>During an interview June 13, 2024, at approximately 10:00 AM the Director of Nursing confirmed that the facility failed to implement the physician prescribed fluid restriction for Resident 178.</p> <p>28 Pa. Code: 211.12 (c)(d)(3)(5) Nursing services</p> <p>28 Pa. Code 211.5(f) Medical records</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on review of clinical records and select facility policy, and staff and resident interviews it was determined that the facility failed to ensure that physician ordered intravenous antibiotics were administered as prescribed for two residents out of 27 sampled (Resident 86 and 72).</p> <p>Findings include:</p> <p>Review of a facility policy titled Administering Medications last reviewed by the facility on April 18, 2024, indicated that medications are administered in a safe and timely manner. It indicated that medications are administered in accordance with prescriber orders, including any required time frame. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and/or the need for additional staffing. Prescribed medications are to be administered within one hour of their prescribed time, unless otherwise specified.</p> <p>Review of Resident 86's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to include quadriplegia (paralysis of all four limbs), infection and inflammatory reaction due to indwelling urethral catheter (a flexible tube which is placed into the bladder to drain urine), and sepsis (life-threatening complication of an infection).</p> <p>A physician order dated April 29, 2024, was noted for a Vancomycin HCL (an antibiotic used to treat bacterial infections) Intravenous Solution 1250 MG/250 ML, use 1250 mg intravenously two times a day for sepsis until June 3, 2024, 23:59, flush with 10cc NSS pre/post admin. To be administered by an RN only.</p> <p>During an interview with Resident 86 on June 11, 2024, at 2:00 PM, he reported that when receiving his IV medication of Vancomycin, nursing staff were often late in hanging his IV. He reported that he was scheduled to receive his dose of IV antibiotics at 12:00 AM and 12:00 PM but that frequently he did not receive his IV medication until 2 or more hours after I was due to receive it.</p> <p>Review of Resident 86's Medication Administration Record (MAR) for May 2024, indicated that he was scheduled to receive Vancomycin at 0000 hours (12:00AM) and 1200 hours (12:00 PM). The MAR indicated that on May 10, 2024, the 1200-hour (12:00 PM) dose was not administered as scheduled.</p> <p>Review of nursing progress notes for May 10, 2024, revealed no documentation of the reason for the missed dose of Vancomycin nor was there any documentation to indicate the physician was notified of the missed dose.</p> <p>Review of a facility-provided real-time administration detail report (a report that indicates the actual time the medication was administered) for administration of IV Vancomycin from April 29, 2024, to May 29, 2024, revealed that on the following dates Resident 86's IV Vancomycin medication was administered one hour or more beyond the physician prescribed time:</p> <p>May 3, 2024 1:27 PM - one hour and 27 minutes overdue</p> <p>May 6, 2024 2:57 PM - two hours and 57 minutes overdue</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>May 15, 2024 1:20 PM - one hour and 20 minutes overdue</p> <p>May 18, 2024 1:36 PM - one hour and 36 minutes overdue</p> <p>May 21, 2024 2:43 PM - two hours and 43 minutes overdue</p> <p>May 23, 2024 1:18 PM - one hour and 18 minutes overdue</p> <p>Interview with the Director of Nursing (DON) on June 13, 2024, at 12:00 PM, confirmed that the facility failed to timely administer 6 doses of the IV antibiotic therapy prescribed for Resident 86, and failed notify the attending physician of a missed dose.</p> <p>Review of Resident 72's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to include poliomyelitis (polio- illness caused by a virus that mainly affects nerves in the spinal cord or brain stem) and sepsis secondary to chronic infected wounds.</p> <p>A physician order dated May 3, 2024, was noted for a Vancomycin HCL (an antibiotic used to treat bacterial infections) Intravenous Solution 500 MG/100 ML, use 500 mg intravenously every eight hours until June 12, 2024, for a diagnosis of osteomyelitis (inflammation of the bone caused by infection), flush with 10cc NSS pre/post admin. To be administered by an RN only.</p> <p>Review of Resident 72's Medication Administration Record (MAR) for May 3 through May 28, 2024, indicated that the resident was scheduled to receive Vancomycin at 0000 hours (12:00AM), 8:00 AM, and 1600 hours (4:00 PM). The MAR indicated that on May 11, 2024, the 1600 hours (4:00 PM) dose was not administered.</p> <p>Review of nursing progress notes for May 11, 2024, revealed no documentation of the reason for the missed dose of Vancomycin nor was there any documentation to indicate the physician was notified of the missed dose.</p> <p>Review of a facility-provided real-time administration detail report (a report that indicates the actual time the medication was administered) for administration of IV Vancomycin from May 3, 2024, through May 31, 2024, revealed that on the following dates Resident 72's IV Vancomycin medication was administered one hour or more beyond the physician prescribed time:</p> <p>May 6, 2024 11:24 AM- 2 hours and 24 minutes overdue</p> <p>May 8, 2024 11:07 AM - hours and 7 minutes overdue</p> <p>May 8, 2024 6:18 PM - 1 hours and 18 minutes overdue</p> <p>May 9, 2024 10:53 AM- 1 hour and 53 minutes overdue</p> <p>May 12, 2024 10:25 AM- 1 hours and 25 minutes overdue</p> <p>May 13, 2024 12:06 PM- 3 hours and 6 minutes overdue</p> <p>May 21, 2024 10:33 AM-1 hours and 33 minutes overdue</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>May 21, 2024 7:51 PM- 2 hours and 51 minutes overdue</p> <p>A physician order dated May 29, 2024, noted an order change to Vancomycin HCL (an antibiotic used to treat bacterial infections) Intravenous Solution 500 MG/100 ML, use 500 mg intravenously two times per day until June 19, 2024, for a diagnosis of osteomyelitis (inflammation of the bone caused by infection), flush with 10 cc NSS pre/post admin. To be administered by an RN only.</p> <p>Review of Resident 72's Medication Administration Record (MAR) for May 29, through May 31, 2024, and June 1, 2024, through June 12, 2024, indicated that the resident was scheduled to receive Vancomycin at 9:00 AM and 21:00 hours (9:00 PM). The MAR indicated that on June 7, 2024, the 2100 hours (9:00 PM) dose was not administered.</p> <p>Review of nursing progress notes for June 7, 2024, revealed no documentation of the reason for the missed dose of Vancomycin nor was there any documentation to indicate the physician was notified of the missed dose.</p> <p>Interview with the Director of Nursing (DON) on June 13, 2024, at approximately 1:00 PM, failed to provide documented evidence that the facility timely administered 8 doses of the IV antibiotic therapy prescribed for Resident 72, and failed to notify the attending physician of two missed doses of the prescribed antibiotic.</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy services</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services</p> <p>28 Pa. Code 211.10 (a)(c)(d) Resident care policies</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</p> <p>Based on observation, a review of clinical records, and staff interview it was determined that the facility failed to ensure the ready availability of necessary emergency supplies for one resident out of two sampled receiving hemodialysis (Resident 59).</p> <p>Findings include:</p> <p>According to the National Kidney Foundation, patients receiving hemodialysis should keep emergency care supplies on hand.</p> <p>A review of the clinical record revealed that Resident 59 was admitted to the facility on [DATE], with a diagnosis to include end stage renal disease, and dependence on renal dialysis (process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood).</p> <p>Resident 59's clinical record indicated he was receiving hemodialysis through a right upper chest Tesio port (dialysis access site) for dialysis access every Tuesday, Thursday and Saturday.</p> <p>Resident 59's clinical record revealed a physician order dated June 11, 2024, for an emergency kit at bedside for the dialysis port .</p> <p>The resident's plan of care, dated May 26, 2024, indicated that staff are to check for a pressure dressing and clamp at bedside for emergency care of the port every shift and document in the Treatment Administration Record (TAR).</p> <p>Observation conducted on June 11, 2024, and at 12:20 PM and on June 12, 2024, at 8:20 AM revealed no emergency kit or supplies available at the resident's bedside.</p> <p>Interview with Employee 4 (registered nurse supervisor) on June 12, 2024, at 8:28 AM, revealed that each resident in the facility receiving dialysis should have emergency supplies at bedside. Employee 4 confirmed that there were no emergency supplies available at Resident 59's bedside.</p> <p>Interview with the Director of Nursing on June 14, 2024, at approximately 11:00 AM confirmed the facility failed to assure an emergency kit was readily available in the event of an emergency with the resident's dialysis access site.</p> <p>28 Pa. Code 211.12 (d)(3)(5) 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>48277</p> <p>Based on observations and staff interview, it was determined that the facility failed to post nurse staffing information on a daily basis to include the resident census and the total number and actual hours worked by licensed and unlicensed staff.</p> <p>Findings Include:</p> <p>Observations in the facility lobby on June 11, 2024, at 8:45 AM and 3:10 PM, and June 12, 2024, at 9:00 AM revealed that the facility's nurse staffing information was not posted in the facility's designated area.</p> <p>An interview with the Director of Nursing on June 12, 2024, at 9:10 AM revealed that the nurse staffing information should be posted daily at the beginning of each shift in a prominent location.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to clinically justify the use of an as needed antipsychotic medication for one of 2 residents reviewed for unnecessary medications (Resident 1).</p> <p>Findings include:</p> <p>A clinical record review revealed Resident 1 was admitted to the facility on [DATE] with diagnoses that include alzheimer's disease and dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 3, 2024, revealed that Resident 1 is severely cognitively impaired with a BIMS score of 7 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 01-07 indicates severe cognitive impairment) and was an independently ambulating resident.</p> <p>A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses that include seizure disorder and hypertension. A review of quarterly, MDS dated [DATE], Section C - Cognitive Patterns, C1000, revealed that Resident 2 has severe impairment to make decisions regarding tasks of daily life. The MDS indicates that a BIMS assessment should not be completed because the resident is rarely or never understood.</p> <p>A review of facility incident and investigation reports dated August 1, 2024 at 2:10 PM revealed Resident 1 was attempting to push Resident 2 who was seated in her wheelchair in the hallway. Resident 2 feet/sneakers were dragging on the floor, causing difficulty moving the wheelchair. Resident 1 became frustrated. Staff attempted to redirect Resident 1 to leave the wheelchair and come into the dining room. Resident 1 then struck Resident 2 with a closed fist to the right side of her face.</p> <p>Resident 1 had a physician order dated August 5, 2023, for Seroquel (an antipsychotic medication) 100 mg by mouth, give one tablet every 24 hours as needed for agitation/aggression (PRN). The medication was discontinued August 6, 2024.</p> <p>A nurses note dated August 5, 2024 at 2:06 PM revealed, 1 to 1 supervision on this shift. There were no behaviors identified for this resident.</p> <p>A review of an August medication administration record (MAR) revealed that on August 5, 2024 at 7:59 PM, Resident 1 received the as needed (PRN) dose of the antipsychotic medication without documented symptoms.</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>There was no evidence at the time of the survey of any clinical documentation regarding increased behaviors at the time of the administration of the PRN (as needed) Seroquel on August 5, 2024 and no clinical justification for the use as an as needed medication for the antipsychotic medication, Seroquel for Resident 1.</p> <p>Interview with the nursing home administrator (NHA) and director of nursing (DON) on August 12, 2024, at approximately 2:00 PM confirmed the resident's clinical records lacked documentation of clinical justification for the prn use of Seroquel.</p> <p>28 Pa Code 211.2(d)(3) Medical Director</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy Services.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER River View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1555 East End Boulevard Plains Twp Wilkes Barre, PA 18711	
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 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>48277</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on a review of facility documents of QA meeting attendance and staff interview, it was determined that the facility failed to ensure that the Medical Director or designee attended quarterly Quality Assurance Process Improvement (QAPI) Committee meetings for two of three quarters reviewed (August 2023 through June 2024).</p> <p>Findings include:</p> <p>A review of QAPI Committee meeting sign-in sheets for the period of August 2023 through June 2024, revealed that the Medical Director or other physician was not in attendance, virtually or in-person, at the QA meetings held from October 2023 through April 2024 missing 2 quarterly meetings (October 27, 2023, and December 5, 2023).</p> <p>An interview with the Nursing Home Administrator (NHA) on June 14, 2024, at 9:00 AM, revealed that the facility was unable to provide documented evidence that the physician attended the facility's QAPI meetings on a quarterly basis as required.</p> <p>28 Pa. Code 211.2 (d)(3)(4)(5)(6) Medical Director</p> <p>28 Pa. Code 201.18 (e)(1)(3) Management</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on a review of clinical records, CDC (centers for disease control) infection control guidance, facility's infection control policy and COVID-19 testing logs, and staff interview it was determined he facility failed to promptly implement infection control practices for cohorting like respiratory infections and testing for COVID-19 to prevent the spread of COVID-19 infections in the facility placing at least 12 residents (Residents 4, 6, 8, 10, 14, 16, 2, 20, 22, 24, 26 and 28) at increased risk for contracting COVID-19 and failed to implement effective interventions to prevent the spread of COVID-19 virus.</p> <p>Findings include:</p> <p>A review of the Pennsylvania Department of Health 2023-PAHAN-694-5-11-2023 update: Interim Infection Prevention and Control Recommendations for COVID-19 in healthcare settings dated May 11, 2023, revealed, this PA HAN (Pennsylvania Health alert Network) provides comprehensive information regarding infection prevention and control for COVID-19 in healthcare settings based on changes made by the Centers for Disease Control and Prevention (CDC) on May 8, 2023.</p> <p>There was no facility specific COVID-19 policy's and procedures available to the survey team at the time of the survey. During an interview August 12, 2024 at 11:00 AM, the Nursing Home Administrator stated the facility follows CDC (Centers for Disease Control) guidelines and recommendations.</p> <p>According to the COVID-19 Infection Control and Outbreak Response for Long-Term Care update as of February 2024 published by the Pennsylvania Department of Health;</p> <p>If a resident develops signs and symptoms of COVID-19:</p> <p>Implement empiric transmission-based precautions while results are pending.</p> <p>Do not place a person with suspected COVID-19 into a COVID-19 Care Unit prior to confirmation of infection by positive test result</p> <p>Identify a COVID-19 Care Unit Dedicated to Monitor and Care for Residents with Confirmed COVID-19</p> <p>Dedicating an area within the facility to cohort residents on isolation for confirmed COVID-19 during their infectious period is best practice for decreasing the likelihood of transmission. Components of a COVID-19 Care Unit ideally include the following:</p> <p>Physical separation from other rooms and spaces where residents are not confirmed with COVID-19;</p> <p>Single-person room(s) with designated bathroom(s);</p> <p>Place a resident with suspected or confirmed COVID-19 in a single- person room.</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 - Many</p>	<p>The door should be kept closed, if safe to do so.</p> <p>The resident should have a dedicated bathroom.</p> <p>If limited single rooms are available, or if numerous residents are simultaneously identified to have symptoms concerning for COVID-19, residents may remain in their current location until cause of symptoms is determined.</p> <p>If cohorting, only residents with the same pathogen should be housed in the same room. Multidrug-resistant organism (MDRO) colonization or infection status, and/or presence of other communicable disease should also be taken into consideration during the cohorting process.</p> <p>Residents testing positive on July 18, 2024, and continued to reside with roommates who were COVID-19 negative during the quarantine period:</p> <p>Resident 3, a COVID-19 positive resident, cohorted with Resident 4, who was COVID-19 negative, in room [ROOM NUMBER] bed 1 and 2, Cypress unit. Resident 4 tested positive on August 13, 2024, after cohorting with Resident 3,(COVID -19 positive).</p> <p>Resident 5, a COVID-19 positive resident,cohorted with Resident 6 who was COVID-19 negative, in room [ROOM NUMBER] bed 1 and 2, Cypress unit Resident 6 tested positive on August 1, 2024, after cohorting with Resident 5, (COVID-19 positive).</p> <p>Resident 7, a COVID-19 positive resident, cohorted with Resident 8, who was COVID-19 negative, in room [ROOM NUMBER] bed 1 and 2, Aspen unit. Resident 8 tested positive on July 25, 2024 after cohorting with Resident 7, (COVID-19 positive).</p> <p>Resident 9, a COVID-19 positive resident, cohorted with Resident 10 who was COVID-19 negative, in room [ROOM NUMBER] bed 1 and 2, Aspen unit, Resident 10 tested positive on August 1, 2024 after cohorting with Resident 9, (COVID-19 positive).</p> <p>Residents testing positive on July 25, 2024, continued to reside with roommates who were COVID-19 negative during the quarantine period:</p> <p>Resident 13, a COVID-19 positive resident, cohorted with Resident 14, who was COVID-19 negative, in room [ROOM NUMBER] bed 1 and 2, Aspen unit.</p> <p>Resident 15, a COVID-19 positive resident, cohorted with Resident 16 who was COVID -19 negative, in room [ROOM NUMBER] bed 1 and 2, Aspen unit.</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 - Many</p>	<p>Resident 17, a COVID-19 positive resident, cohorted with Resident 2, who was COVID-19 negative, in room [ROOM NUMBER] bed 1 and 2, Aspen unit.</p> <p>Resident 19, a COVID-19 positive resident, cohorted with Resident 20, who was COVID-19 negative, in room [ROOM NUMBER] bed 1 and 2, Birch unit.</p> <p>Resident 21, a COVID-19 positive resident, cohorted with Resident 22, who was COVID-19 negative, in room [ROOM NUMBER] bed 1 and 2, Birch unit.</p> <p>Residents testing positive on August 1, 2024, and at the time of the survey beginning on August 12, 2024, continued to reside with roommates who were COVID-19 negative:</p> <p>Resident 23, a COVID-19 positive resident, cohorted with Resident 24 who was COVID-19 negative, in room [ROOM NUMBER] bed 1 and 2 Aspen unit.</p> <p>Resident 25, a COVID-19 positive resident, cohorted with Resident 26 who was COVID-19 negative, in room [ROOM NUMBER] bed 1 and 2 Aspen unit.</p> <p>Testing logs were requested at the time of the survey ending August 12, 2024, to which the facility provided a sheet of paper entitled COVID Positive Residents testing dates were between July 18, 2024, and August 6, 2024. It could not be determined that all staff working on the affected second floor were COVID-19 tested as per CDC guidelines. No COVID-19 testing logs for staff were provided to the survey team during the survey.</p> <p>The facility's infection control logs did not identify any signs or symptoms displayed by any of the residents or staff.</p> <p>At the time of the survey, there was no documentation of any contact tracing for residents or staff.</p> <p>There was no evidence at the time of the survey the facility followed their COVID-19 policy and CDC guidance for COVID-19 testing, contract tracing and cohorting residents positive or exposed to the COVID-19 virus.</p> <p>During an interview July 26, 2024, at 9:00 AM, the Nursing Home Administrator and the Director of Nursing confirmed the facility did not move any of the COVID-19 positive residents, or their COVID-19 negative roommates on the second floor unit because they were under the assumption that cohorting COVID-19 positive residents was no longer recommended.</p> <p>28 Pa Code 211.12 (c)(d)(1)(5) Nursing services</p> <p>28 Pa. Code 211.10 (a)(c) Resident care policies</p>		