

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER St John Specialty Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Wittenberg Way Mars, PA 16046	

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 - Few</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** 46337</p> <p>Based on review of facility policy, observation, and staff interview it was determined that the facility failed to provide a dignified dining experience by failing to provide meals timely for one of six residents (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility policy Maintaining Respect and Dignity of the Resident dated 8/30/24, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. It was indicated residents shall be treated with dignity and respect at all times.</p> <p>Review of the facility policy Resident Rights dated 8/30/24, indicated the facility will inform a resident at the time of admission, and periodically throughout his/her stay, of the rights afforded to all residents.</p> <p>Review of the admission record indicated Resident R1 admitted to the facility on [DATE], and readmitted [DATE].</p> <p>Review of Resident R1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 8/29/24, indicated the diagnoses of anxiety, depression, and epilepsy (a brain condition that causes recurring seizures).</p> <p>During an observation on 10/8/24, at 11:31 a.m. Resident R1's roommate lunch tray was dropped off in his room. Resident R1 did not receive his meal.</p> <p>During an interview and observation on 10/8/24, at 11:54 a.m. Resident R1 was observed with no meal and indicated he is hungry. Resident R1 indicated it bothers him that his roommate gets food before him.</p> <p>During an interview on 10/8/24, at 11:55 a.m. Resident R1's roommate was observed finished with his meal sleeping in bed.</p> <p>During an observation on 10/8/24, at 12:17 p.m. Nurse Aide, Employee E10 was observed entering Resident R1's room with his meal. A total of 46 minutes since Resident R1's roommate received his meal.</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 - Few</p>	<p>During an interview on 10/8/24, at 12:18 p.m. Nurse Aide, Employee E10 confirmed Resident R1's roommate got his meal prior to Resident R1.</p> <p>During an interview on 10/9/24, at 12:24 p.m. the Director of Nursing confirmed the facility failed to provide a dignified experience by failing to provide meals timely for one of six residents (Resident R1).</p> <p>28 Pa Code: 201.29 (i) Resident rights.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>41984</p> <p>Based on review of facility policy, Resident Group interviews, Resident Council meeting minutes, grievances, and staff interview it was determined the facility failed to consider the views of a resident and/or family and act promptly on grievances and recommendations concerning issues of resident care and life in the facility for three of four months (July, August, September 2024).</p> <p>Findings include:</p> <p>Review of facility policy titled Grievance Policy, last reviewed 8/30/24, indicated facility will have a procedure on how to file a grievance or complaint available to the resident and will ensure a prompt resolution of all grievance including the residents' right.</p> <p>During a Resident Group meeting held on 10/8/24, six of six members voiced concerns over food quality, and five of six residents voiced concerns over call bells. Resident R503 reported pasta is hard, carrots aren't cooked and has complained to management for the last 3-4 months with no resolve, also staff come in when calls bells are on, shuts them off and doesn't attend to their needs. Resident R504 voiced concerns that pasta is undercooked, lunch time tray times vary widely, and nothing is done about their concerns. Resident 505 voiced concerns on call bells, not tending to residents.</p> <p>Review of Resident Council meeting minutes revealed food quality and call bell concerns as follows:</p> <p>7/10/24, Prior meeting concerns, Pasta is too hard, grilled cheese not cooked, meals are late, call bells are turned off before need is met</p> <p>-New: Meat is dry, staff talk to each other during care</p> <p>8/14/24, Prior concerns: Some food, nursing concerns continue.</p> <p>-New: Pasta not cooked/noodles dry, carrots. 1 shower room is not enough. Staff turn off call bells before doing care. Staff talk to each other during care.</p> <p>9/11/24 Prior concerns: Pasta not cooked/noodles dry, carrots. 1 shower room is not enough. Staff turn off call bells before doing care. Staff talk to each other during care.</p> <p>-New: Meat is too hard, can't eat, grilled cheese is not grilled, staff talking to each other during care, call bells turn lights off without addressing needs</p> <p>The facility could not provide documentation that the facility investigated and provided a resolution of the Resident Council concerns.</p> <p>During an interview on 10/10/24, at 10:00 a.m. the Director of Activities Employee E6 confirmed the facility did not resolve the above concerns.</p> <p>28 Pa. Code: 201.18(e)(4) Management</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code: 201.29(i) 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 - Few</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** 46167</p> <p>Based on facility policy, resident record review, review of facility documents, and staff interview, the facility failed to provide an environment free from verbal abuse for one of three residents (Resident R400).</p> <p>Findings include:</p> <p>Review of facility policy Abuse, Prevention of Resident Abuse, Neglect, Mental Abuse, Reports of Theft, Exploitation and Misappropriation of Property dated 8/30/24, indicated that the facility will provide a safe and secure environment for all residents and will protect a resident's right to be free from any form of abuse, mental abuse, neglect, reports of theft, exploitation or misappropriation of property.</p> <p>Review of the clinical record revealed that Resident R400 was admitted to the facility on [DATE].</p> <p>Review of Resident 400's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 9/3/24, indicated diagnoses of dementia (neuro-cognitive disorder impacting reasoning, judgment, and memory), unspecified visual loss, and muscle weakness.</p> <p>Review of documentation provided by the facility revealed that on 7 /13/24, Speech Therapist (ST) Employee E14 witnessed Nurse Aide (NA) Employee E15 yell at Resident R400 in the dining room. Allegedly NA Employee E15 ripped the pillow out of Resident R400's hands because she was getting the pillow in her food and yelled at her Why don't you go the fuck to sleep?. Resident R400 sat quietly in her chair with her eyes closed.</p> <p>Review of a written statement from ST Employee E14 dated 7/12/24, stated that Resident R 400 was placed at dining room table and had a pillow on her lap. She placed the pillow on top of her tray of food and NA Employee E15 then went over to Resident R400 and ripped the pillow out of her hands and said, 'Why don't you go the fuck to sleep?'. Incident was reported to Director of Nursing.</p> <p>Review of a written statement from NA Employee E15 dated 7/12/24, stated Raised my voice to Resident R400. It was uncalled for and I am ashamed of my actions.</p> <p>During an interview on 10/10/24, at 9:35 a.m. Nursing Home Administrator confirmed that the facility failed to provide an environment free from verbal abuse for Resident R400.</p> <p>28 Pa. Code: 201.18(b)(1)(2)</p> <p>28 Pa. Code 201.29(a)(c)(d)(j)(m)</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** 41984</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of four residents sampled with facility-initiated transfer (Residents R16 and R37).</p> <p>Findings include:</p> <p>Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE].</p> <p>Review of Resident R16's MDS (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 9/3/24, indicated diagnoses of aftercare following joint replacement, urinary tract infection and hyperlipidemia (abnormally high levels of lipids or fats in the blood).</p> <p>Review of the clinical record indicated Resident R16 was transferred to hospital on 8/6/24 and returned to the facility on [DATE].</p> <p>Review of Resident R16's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of Resident R37's admission record indicated she was originally admitted on [DATE], with diagnoses that included venous insufficiency, retention of urine and colostomy (procedure that creates an opening in the abdominal wall to divert the large intestine to an external pouch).</p> <p>Review of Resident R37's clinical record revealed that the resident was transferred to the hospital on 6/9/24, and returned to the facility on [DATE].</p> <p>Review of Resident R37's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>During an interview on 10/9/24 at 1:15 p.m. the Assistant Director of Nursing (ADON) confirmed that the facility failed to provide the necessary information for Resident R16 and R37.</p> <p>28 Pa. Code 201.29(a)(c.3)(2) Resident rights.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 41984</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for one of four residents (Residents R16).</p> <p>Findings include:</p> <p>Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE].</p> <p>Review of Resident R16's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 9/3/24, indicated diagnoses of aftercare following joint replacement, urinary tract infection and hyperlipidemia (abnormally high levels of lipids or fats in the blood).</p> <p>Review of the clinical record indicated Resident R16 was transferred to hospital on 8/6/24 and returned to the facility on [DATE].</p> <p>Review of Resident R16's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of the Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>During an interview on 8/15/24 at 11:05 a.m. the Director of Nursing (DON) confirmed the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for one of four residents (Residents R16).</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 - Few</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** 41984</p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for one of four resident hospital transfers (Resident R16).</p> <p>Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE].</p> <p>Review of Resident R16's MDS dated [DATE], indicated diagnoses of aftercare following joint replacement, urinary tract infection and hyperlipidemia (abnormally high levels of lipids or fats in the blood).</p> <p>Review of the clinical record indicated Resident R16 was transferred to hospital on 8/6/24 and returned to the facility on [DATE].</p> <p>Review of Resident R16's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 8/6/24.</p> <p>During an interview on 10/9/24, at 1:15 p.m. Assistant Director of Nursing Employee E3 confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for one of four resident hospital transfers as required.</p> <p>28 Pa. Code 201.29 (a)(c.3)(2) Resident rights</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on a review of the RAI (Resident Assessment Instrument), clinical records, and staff interviews it was determined that the facility failed to make certain that resident assessments were accurate for two of twelve residents (Residents R1, and R128).</p> <p>Findings include:</p> <p>The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of resident care needs), dated October 2024, indicated the following:</p> <p>Section A2105 Discharge Status: This item documents the location to which the resident is being discharged at the time of discharge. Select the two-digit code that corresponds to the resident's discharge status. Code 01, Home/Community: if the resident was discharged to a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person.</p> <p>Section P0100 Physical Restraints: Physical restraints are any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Code 1 if a restraint is used less than daily during a seven day look back period.</p> <p>Review of the admission record indicated Resident R1 admitted to the facility on [DATE].</p> <p>Review of Resident R1's MDS dated [DATE], indicated the diagnoses of anxiety, depression, and epilepsy (a brain condition that causes recurring seizures.) Section P0100. Physical Restraints indicated the resident uses a limb restraint in bed.</p> <p>During an observation and interview on 10/9/24, at 10:10 a.m. no restraints were observed on Resident R1. Resident R1 indicated he does not utilize any limb restraints.</p> <p>Review of the admission record indicated Resident R128 was admitted to the facility on [DATE].</p> <p>Review of Resident R128's MDS dated [DATE], indicated the diagnoses of anemia (too little iron in the body causing fatigue), urinary tract infection (infection in any part of the kidneys, bladder, or urethra), and cardiomyopathy (disease of the heart muscle). Section A2105 was entered as 04, which indicated that resident R128 was discharged to a Short-Term General Hospital.</p> <p>Review of progress notes dated 7/12/24, indicated that Resident R128 was discharged to Personal Care.</p> <p>(continued on next page)</p>		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/9/24, at 1:25 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E4 confirmed the facility failed to make certain that resident assessments were accurate for two of twelve residents (Residents R1, and R128). 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing Services.

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility policy, clinical records, and staff interview, it was determined the facility failed to update a care plan for one of five residents (Resident R29) to accurately reflect the current status of the resident and care needs.</p> <p>Findings include:</p> <p>Review of the facility policy Comprehensive Plan of Care dated 8/30/24 indicated specific individualized steps or approaches that staff will take to assist the resident to achieve the goals will be identified. These approaches serve as instructions for resident care and provide for continuity of care by all staff. Short and concise instructions should be written.</p> <p>Review of the admission record indicated Resident R29 admitted to the facility on [DATE].</p> <p>Review of Resident R29's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/2/24, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), coronary artery disease (narrow arteries decreasing blood flow to heart), and heart failure (heart doesn't pump blood as well as it should).</p> <p>Review of Resident R29's physician order dated 10/8/24, indicated to give Eliquis (a medication that thins the blood) daily.</p> <p>Review of Resident R29's care plan on 10/10/24, at 12:19 p.m. failed to identify the use of the blood thinner and the monitoring/management of its use.</p> <p>Interview on 10/10/24, at 12:20 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E4 confirmed the facility failed to identify the blood thinner for Resident R29's care plan and the facility failed to update a care plan for one of five residents (Resident R29) to accurately reflect the current status of the resident and care needs.</p> <p>28 Pa. Code: 211.11(a)(b)(c)(d) Resident care plan.</p> <p>28 Pa. Code: 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to provide appropriate care and services to maintain activities of daily living (ADLs) for communication for one of six residents (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility policy Maintaining Respect and Dignity of the Resident dated 8/30/24, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. It was indicated residents shall be treated with dignity and respect at all times.</p> <p>Review of the facility policy Clinical Procedure Augmentative Communication Device dated 8/30/24, indicated communication boards and/or augmentative devices may be provided to individuals who are limited in their ability to communicate verbally but are able to communicate by using a device with pictures and/or words. The individual, speech therapist, or physician will identify a need for augmentative communication, and a screen or order may be requested from physician or licensed independent provider. Evaluation, treatment, and progress are documented.</p> <p>Review of the admission record indicated Resident R1 admitted to the facility on [DATE], and readmitted [DATE].</p> <p>Review of Resident R1's MDS dated [DATE], indicated the diagnoses of encephalopathy (a disease that affects brain structure or function), aphasia (a disorder that affects language and communication), and epilepsy (a brain condition that causes recurring seizures).</p> <p>Review of Resident R1's Speech Language Pathology Comprehensive Evaluation dated 2/23/24, indicated the resident uses a communication device at baseline function.</p> <p>Review of Resident R1's physician order dated 4/16/24, indicated nurse to ensure that Dynavox (a device that assists individuals who are unable to communicate reliably with their own voices due to cognitive, language and physical impairments) is charging while the resident sleeps every day at bedtime.</p> <p>Review of Resident R1's care plan dated 7/20/16, last revised 6/12/24, indicated the resident has conditions that impair his ability to communicate his wants and/or needs. Interventions included to use his Dynavox to communicate.</p> <p>During an observation on 10/7/24, at 11:04 a.m. Resident R1's Dynavox was observed sitting on a table and not in reach to Resident R1. Resident R1 was unable to communicate.</p> <p>During an interview on 10/07/24, at 11:07 a.m. Licensed Practical Nurse, Employee E9 stated Resident R1 communicates with hand gestures, sign language, and a speech board. LPN, Employee E9 confirmed Resident R1's Dynavox was not in reach.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER St John Specialty Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Wittenberg Way Mars, PA 16046	

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/08/24, at 12:18 p.m. Nurse Aide, Employee E10 indicated Resident R1 uses his Dynavox to communicate.</p> <p>During an interview on 10/9/24 10:07 a.m. Resident R1 Indicated he prefers to use Dynavox for communication.</p> <p>Review of Resident R1's clinical record on 10/10/24, at 10:10 a.m. failed to include an order for the use of a Dynavox communication device.</p> <p>During an interview on 10/10/24, at 9:20 a.m. the Director of Nursing confirmed the facility failed to provide appropriate care and services to maintain activities of daily living (ADLs) for communication for one of six residents.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure a resident had a physician order for care and management of an invasive catheter for one of one resident formerly on dialysis (Resident R122).</p> <p>Findings include:</p> <p>Review of facility policy Standards of Care dated 8/30/24, indicated a detailed care plan based on the resident's assessment, including specific interventions, goals, and responsible staff members. Ensure that all staff members are adequately trained in providing quality care, including specific skills needed for resident needs.</p> <p>Review of the admission record indicated Resident R122 was admitted to the facility on [DATE].</p> <p>Review of Resident R122's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/8/24, indicated the diagnosis of anoxic brain damage (injury to the brain due to a lack of oxygen), renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), and viral hepatitis (disease of the liver caused by a virus).</p> <p>Review of Resident R122's current physician orders on 10/9/24, at 1:45 p.m. failed to include orders for care and management of the Tesio catheter (a long-term vascular access device for hemodialysis - a treatment for kidney failure that rids your body of unwanted toxins, waste products, and excess fluids by filtering your blood).</p> <p>Review of the Resident R122's current care plan on 10/9/24, at 2:00 p.m. indicated I will remain free from infection related to my dialysis catheter. The care plan failed to identify care and management of the Tesio catheter and site.</p> <p>Observation of Resident R122 on 10/10/24, at 2:05 p.m. indicated two Tesio catheter ports sticking out from under the resident's shirt on the left upper arm.</p> <p>Interview with Resident R122 on 10/10/24, at 2:05 p.m. indicated she last had dialysis over a month ago and they haven't done anything with the Tesio catheter since.</p> <p>Observation with Licensed Practical Nurse (LPN) Employee E5 on 10/10/24, at 2:10 p.m. indicated a Tesio catheter in the left upper chest with dark dried blood at the insertion site under a clear, crumpled dressing. There was not a readable date on the dressing.</p> <p>Interview with LPN Employee E5 confirmed the appearance of the Tesio site, dressing, and that Resident R122 hasn't had dialysis in over a month. LPN Employee E5 further indicated staff of the facility do not handle the Tesio catheters.</p> <p>Interview with the Director of Nursing on 10/10/24, at 2:25 p.m. confirmed the facility failed to ensure a resident had a physician order for care and management of an invasive catheter for one of one resident formerly on dialysis (Resident R122).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</p> <p>28 Pa. Code 201.29(a)(c)(d) Resident rights</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility policy, record review, and resident and staff interviews, and observations it was determined that the facility failed to provide a resident environment free of potential accidental hazards for one of five residents (Resident R30).</p> <p>Findings include.</p> <p>Review of the facility policy Resident Accidents/Incidents dated 8/30/24, indicated the facility will provide a safe and secure environment for residents and will be proactive in the prevention of accidents and incidents.</p> <p>Review of the admission record indicated Resident R30 was admitted to the facility on [DATE].</p> <p>Review of Resident R30's Minimum Data Set (MDS- a periodic assessment of care needs) dated 7/24/24, indicated the diagnoses of hemiparesis (one-sided muscle weakness), diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and respiratory failure (a serious condition that makes it difficult to breathe on your own). Section C0500 the Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 0-7: severe impairment. Resident R30's score of 3. Section GG indicated Resident R30 requires supervision of oversight or cueing with set up help only.</p> <p>Review of Resident R30's clinical record on 10/8/24, at 2:50 p.m. failed to include an assessment, identify the risks (burns and fires), ongoing evaluation, and physician's orders for the personal microwave in his room.</p> <p>Review of Resident R30's current care plan on 10/8/24, at 3:00 p.m. indicated a behavior problem that included delusional behavior (fixed, false conviction in something that is not real or shared by other people), striking out, hitting, and knocking over objects, and stockpiling food in his room. Review of the care plan failed to include potential risk for burns and fires from personal microwave in his room.</p> <p>Observation on 10/7/24, at 10:41 a.m. Resident R30 was in a wheelchair with a splint on his right hand, self-propelling independently of staff, down the hallway with his left hand.</p> <p>Observation of Resident R30's room on 10/7/24, at 10:44 a.m. indicated a large microwave surrounded by personal items.</p> <p>Interview with Resident R30 indicated he uses the microwave to heat his tea up.</p> <p>Interview with Nurse Aide (NA) Employee E11 on 10/8/24, at 11:24 a.m. indicated Resident R30 has his ups and downs when asked if he was safe to use his microwave on his own.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/8/24, at 12:50 p.m. Licensed Practical Nurse (LPN) Employee E12 confirmed the personal microwave was in Resident R30's room and if he wanted to, he was capable of using it with his good hand.</p> <p>Interview on 10/8/24, at 12:56 p.m. the Nursing Home Administrator (NHA) confirmed Resident R30 is not alert and oriented and has a traumatic brain injury (usually results from a violent blow or jolt to the head or body). The NHA indicated the facility did not have a policy for personal microwave use, and confirmed a personal microwave was in Resident R30's room, despite the severe cognitive impairment BIMS score of 3 and the failed to provide a resident environment free of potential accidental hazards for one of five residents (Resident R30).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 45577</p> <p>Based on facility policy, clinical record review, and staff interviews, it was determined the facility failed to ensure that appropriate treatment and services were provided for five of seven residents with an indwelling urinary catheter and bladder needs (Resident R39, R44, R63, R122, and R236).</p> <p>Findings include:</p> <p>A review of facility policy Catheter Care dated 8/30/24, indicated the facility will provide catheter care, consistent with the resident's comprehensive assessment and plan of care to prevent infection of the resident's urinary tract. Be sure the catheter tubing and drainage bag are kept off the floor and below the level of the bladder. Catheter bags should be maintained in a dignity bag at all times except when care is being provided.</p> <p>Review of Resident R39's clinical admission record indicated that resident was admitted to the facility 8/26/24, with diagnoses chronic kidney disease (gradual loss of kidney function that can lead to kidney failure), bladder cancer, and atrophy of kidney (a condition where one or both kidneys shrink and loss function due to various reasons).</p> <p>Review of Resident R39's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/2/24, indicated that diagnoses remain current upon review. Section H, Bladder and Bowel, indicated that an indwelling catheter was present.</p> <p>During an observation on 10/7/24, at 11:30 a.m., Resident R39 was in bed with his urinary drainage bag uncovered and laying on the floor.</p> <p>During an interview on 10/7/24, at 11:33 a.m., Licensed Practical Nurse (LPN) Employee E2 confirmed that Resident R39's urinary drainage bag was uncovered and laying on the floor.</p> <p>Review of Resident R39's physician order dated 8/27/24, indicated foley catheter (document FR size and balloon in Notes) change PRN [as needed] clogging/dislodgement. Further review of physician orders failed to indicate a diagnosis for indwelling catheter use, failed to include physician orders for care to indwelling catheter site, and failed to include the size tubing and balloon used for Resident R39's indwelling catheter.</p> <p>Review of Resident R39's current plan of care failed to indicate diagnosis for indwelling catheter use and failed to include the size tubing and balloon used for Resident R39's indwelling catheter.</p> <p>Review of Resident R44's clinical admission record indicated that resident was admitted to the facility 8/10/23, with diagnoses of high blood pressure, heart failure (heart doesn't pump blood as well as it should), and chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe).</p> <p>Review of Resident R44's MDS dated [DATE], indicated the diagnoses remain current.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R44's physician order dated 10/8/24, indicated bladder scan (a device that uses sound waves to create a picture of the inside of the bladder) every eight hours for three days.</p> <p>Review of physician progress note dated 10/9/24, indicated urinary stent (thin, flexible tubes that hold open the ureters, allowing urine to flow from the kidneys to the bladder) and urine infection/stones.</p> <p>Review of Resident R44's care plan failed to indicate problems or interventions for urinary retention, urinary infection, or the bladder scans.</p> <p>Interview of 10/10/24, at 11:10 a.m. Assistant Director of Nursing (ADON) Employee E3 confirmed the urinary retention and bladder scans were not included in the care plan as required for Resident R44.</p> <p>Review of Resident R63's clinical admission record indicated that resident was admitted to the facility 4/22/23, with diagnoses of high blood pressure, anxiety, and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>Review of Resident R63's MDS dated [DATE], indicated the diagnoses remain current.</p> <p>Review of Resident R63's physician orders dated 9/27/24, indicated to apply an external female urinary catheter. Change daily for non-healing wound and incontinence (inability to control bladder).</p> <p>Review of Resident R63's Treatment Administration Record (TAR) failed to include the orders for external female catheter.</p> <p>Observation of Resident R63 on 10/10/24, at 10:00 a.m. failed to include the use of an external female catheter as ordered.</p> <p>Interview on 10/10/24, at 10:14 a.m. the Director of Nursing indicated We don't have the supplies yet fifteen days after the order was written.</p> <p>Interview on 10/10/24, at 11:00 a.m. the Director of Nursing indicated The supplies arrived the other day and somebody put them straight in the closet and staff were unaware they arrived.</p> <p>Review of Resident R122's clinical admission record indicated that resident was admitted to the facility 8/8/24, with diagnoses of anoxic brain damage (injury to the brain due to a lack of oxygen), renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), and viral hepatitis (disease of the liver caused by a virus).</p> <p>Review of Resident R122's MDS dated [DATE], indicated the diagnoses remain current.</p> <p>Review of Resident R122's physician orders dated 10/4/24, indicated to irrigate (flush) catheter with Renacidin (a sterile irrigating solution used to treat kidney and bladder stones and prevent clogs in bladder catheters and tubes) once daily.</p> <p>Observation on 10/8/24, at 10:00 a.m. Resident R122's bedside stand had a bladder irrigation bottle filled with a clear liquid with a syringe lying in it. The irrigation bottle was dated 10/7/24.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 10/8/24, at 10:10 a.m. LPN Employee E17 confirmed the clear irrigation liquid in the bottle should not have been left in the bottle, nor the syringe, and that it was dated from the day prior.</p> <p>Review of Resident R236's clinical admission record indicated that resident was admitted [DATE], with diagnoses benign prostatic hyperplasia (a condition in which the flow of urine is blocked due to the enlargement of the prostate gland), chronic kidney disease, and surgical aftercare for genitourinary (urinary and reproductive) system.</p> <p>During an observation on 10/7/24, at 1:43 p.m., Resident R236 was in bed with his urinary drainage bag uncovered, hanging from the frame of his bed.</p> <p>During an interview on 10/7/24, at 1:45 p.m., Licensed Practical Nurse (LPN) Employee E2 confirmed that Resident R236's urinary drainage bag was uncovered.</p> <p>Review of Resident R236' physician order dated 10/8/24, indicated foley catheter (document FR size and balloon in Notes) change PRN [as needed] for clogging/dislodgement. Further review of physician orders failed to indicate a diagnosis for indwelling catheter use, failed to include physician orders for care to indwelling catheter site, and failed to include the size tubing and balloon used for Resident R236's indwelling catheter.</p> <p>Review of Resident R236's current plan of care failed to indicate diagnosis for indwelling catheter use and failed to include the size tubing and balloon used for Resident R39's indwelling catheter.</p> <p>During an interview of 10/22/24, at 11:15 a.m., the Director of Nursing (DON) the facility failed to ensure that appropriate treatment and services were provided for five of seven residents with an indwelling urinary catheter and bladder needs (Resident R39, R44, R63, R122, and R236).</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</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 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>46336</p> <p>Based on facility policy review, clinical record review, resident, and staff interviews, it was determined that the facility failed to provide colostomy care and services consistent with professional standards of practice for one of two residents reviewed (Resident R63).</p> <p>Findings include:</p> <p>Review of facility policy Colostomy/Ileostomy/Urostomy Care and Management dated 8/30/24, indicated to document the plan of care on the patient's electronic medical record including details such as: the size, shape, and color of stoma as well as the size and type of ostomy appliance being used.</p> <p>Review of Resident R63's clinical admission record indicated that resident was admitted to the facility 4/22/23, with diagnoses of high blood pressure, anxiety, and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>Review of Resident R63's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/11/24, indicated the diagnoses remain current.</p> <p>Review of Resident R63's physician orders dated 1/17/24, indicated to assist resident in changing colostomy (a surgical procedure that redirects your colon to a new opening in the abdominal wall) and wafer. The order failed to include size and type of ostomy appliance being used.</p> <p>Review of Resident R63's current care plan on 10/8/24, at 11:49 a.m. failed to include size and type of ostomy appliance being used.</p> <p>Interview on 10/9/24, at 10:34 a.m. Licensed Practical Nurse (LPN) Employee E5 indicated the facility gets her supplies delivered straight to her room. She indicated they do not include specifications in the order and care plan.</p> <p>Interview on 10/9/24, at 2:00 p.m. the Director of Nursing confirmed the facility failed to provide colostomy care and services consistent with professional standards of practice for one of two residents reviewed (Resident R63).</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</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 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on clinical records and facility policy review, and staff interview, it was determined that the facility failed to ensure that a resident who displayed mental or psychosocial adjustment difficulties received appropriate treatment and services for one of three residents (Resident R22).</p> <p>Findings include:</p> <p>Review of the facility policy Managing Behaviors dated 8/30/24, indicated when a behavioral concern emerges, an attempt to intervene as a team will be made. The plan should be documented. Document behaviors once the plan is initiated.</p> <p>Review of the Director of Social Services job description indicated it is the responsibility of the Director of Social Services to perform functions of a social worker including, being an interdisciplinary care plan team member, develop resident care plans, being a resident advocate, and educate residents, families and staff as it relates to psycho-social needs.</p> <p>Review of the clinical record indicated Resident R22 was admitted to the facility on [DATE].</p> <p>Review of Resident R22's Minimum Data Set (MDS- assessment of a resident's abilities and care needs) dated 9/2/24, indicated diagnoses of depression, anxiety, and bipolar disorder (a serious mental illness characterized by extreme mood swings, which can include extreme excitement episodes or extreme depressive feelings.).</p> <p>Review of the nursing progress notes dated 8/9/24, indicated the resident was at the nurses' station screaming loudly attempting to throw himself out of his wheelchair several times. Resident stating loudly, I want to commit suicide, I can't do this anymore, I want to commit suicide Unable to redirect from yelling out. It was indicated the physician was called and ordered a one-time dose of Xanax (medication used to treat anxiety and panic disorders) and for the Unit manager to call psychiatric services to discuss behaviors. It was indicated the resident's behavior would be monitored and the Social Worker was updated.</p> <p>Review of Resident R22's physician order dated 8/9/24, indicated to administer one tablet of 0.25 mg alprazolam (generic medication for Xanax) for one day for agitation/anxiety/suicidal thoughts/yelling, give one dose now, call psychiatric services at this time.</p> <p>Review of Resident R22's clinical record on 8/9/24, failed to indicate psychiatric services was notified as per the physician order.</p> <p>Review of Resident R22's psych progress note dated 9/9/24, indicated the resident denied suicide attempt, but states he went to the hospital once because he wanted to walk into traffic on the Golden Gate Bridge.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/10/24, at 10:39 a.m. Social Worker, Employee E13 indicated if a resident is expressing suicidal ideation, the Director of Nursing and physician is notified immediately. It was then indicated psychiatric services would be notified depending on the situation and it would be documented in the clinical record who was notified and what interventions were implemented. Social Worker, Employee E13 stated she does not recall being notified of Resident R22's suicidal ideation on 8/9/24.</p> <p>Review of Resident R22's clinical record on 10/10/24 at 10:42 a.m. failed to include a care plan for suicidal ideation.</p> <p>During an interview on 10/10/24, at 10:45 a.m. the Director of Nursing and Nursing home Administrator confirmed the facility failed to ensure that a resident who displayed mental or psychosocial adjustment difficulties received appropriate treatment and services for one of three residents (Resident R22).</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on a review of facility policy, clinical records and staff interviews it was determined that the facility failed to ensure that a resident's drug regimen was free of unnecessary medication for one of two residents. (Resident R84)</p> <p>Findings include:</p> <p>Review of the facility policy Psychotropic Drugs dated 8/30/24, indicated a psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. The evaluation and documentation should address whether the psychotropic is still needed on a as needed basis, what the benefit of the medication is to the resident, and whether the resident's expressions or indications of distress have improved as a result of the medication.</p> <p>Review of the clinical record indicated Resident R84 was admitted to the facility on [DATE], with diagnoses of Parkinson's Disease (a movement disorder of the nervous system that worsens over time), depression, and intellectual disabilities.</p> <p>Review of Resident R84's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/2/24, indicated diagnoses were current.</p> <p>Review of a physician order dated 4/25/24, indicated to administer 1 mg tablet of Ativan (medication used to treat anxiety) at bedtime for routine sleeping care.</p> <p>Review of a physician order dated 4/25/24, indicated to administer 0.5 mg tablet of Lorazepam (medication used to treat anxiety) at bedtime as needed for routine sleeping care.</p> <p>Review of Resident R84's clinical record on 10/9/24, at 10:00 a.m. failed to indicate a diagnosis of insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep) or care plan related to difficulty sleeping.</p> <p>During an interview on 10/9/24, at 10:41 a.m. the Director of Nursing (DON) confirmed that the facility failed to ensure that a resident's drug regimen was free of unnecessary medication.</p> <p>28 Pa. Code: 201.18(e)(1) Management.</p> <p>28 Pa. Code: 211.9(a)(1)(g) Pharmacy services.</p> <p>28 Pa. Code: 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on a review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to limit as needed antipsychotic drugs to 14 days for two of four residents (Resident R84 and R122).</p> <p>Findings include:</p> <p>Review of the facility policy Psychotropic Drugs dated 8/30/24, indicated a psychotropic drug is any drug that affects brain activities associated with mental processes and behaviors, to include Anti-anxiety medications. All PRN (as needed) psychotropic medications will have a limitation of 14 days duration for orders.</p> <p>Review of the clinical record indicated Resident R84 was admitted to the facility on [DATE], with diagnoses of Parkinson's Disease (a movement disorder of the nervous system that worsens over time), depression, and intellectual disabilities.</p> <p>Review of Resident R84's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/2/24, indicated diagnoses were current.</p> <p>Review of a physician order dated 4/25/24, indicated to administer 0.5 mg tablet of Lorazepam (a psychotropic drug used to treat anxiety, insomnia, acute seizures, and sedation) at bedtime, as needed, for routine sleeping care. The physician order extended past the 14-day limit.</p> <p>Review of Resident R84's current care plan dated 7/29/24, failed to indicate a problem or interventions for lorazepam use, monitoring of, or sleep.</p> <p>Review of the admission record indicated Resident R122 was admitted to the facility on [DATE].</p> <p>Review of Resident R122's MDS dated [DATE], indicated the diagnosis of anoxic brain damage (injury to the brain due to a lack of oxygen), renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), and viral hepatitis (disease of the liver caused by a virus).</p> <p>Review of Resident R122's current physician orders on 8/19/24, indicated Lorazepam 0.5mg (milligrams) every four hours as needed for break through seizures.</p> <p>Review of Resident R122's current care plan dated 10/9/24, failed to indicate a problem or interventions for lorazepam use, monitoring of, or seizure activity.</p> <p>Review of Resident R122's clinical record failed to indicate a renewal date of the Lorazepam ordered on 8/19/24, exceeding the 14-day duration maximum requirement.</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>During an interview on 10/9/24, at 10:41 a.m. the Director of Nursing confirmed the facility failed to limit as needed antipsychotic drugs to 14 days as required for two of four residents (Resident R84 and R122).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>28 Pa Code 211.12 (d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medications in one out of two medications rooms (Wellstep) and failed to properly store a medication on one of four medications carts (2nd Floor Middle Hall Medication Cart).</p> <p>Findings include:</p> <p>Review of the facility policy Storage of Medication dated [DATE], indicated medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier.</p> <p>During an observation on [DATE], at 1:27 p.m. of the 2nd Floor Middle Hall Medication Cart indicated the following medications were expired:</p> <ul style="list-style-type: none"> - Resident R2's Victoza pen (prefilled pen used to help control blood sugar, insulin levels, and digestion) expired [DATE]. <p>During an interview on [DATE], at 1:28 p.m. Licensed Practical Nurse (LPN) Employee E18 confirmed the above findings.</p> <p>During an observation on [DATE], at 1:31 p.m. of the Wellstep Medication Room indicated the following medications and supplies were expired:</p> <ul style="list-style-type: none"> -(2) boxes of Needles Thin Wall, Sterile 22 gauge x 1' 1 per pack Expired [DATE] -(3) boxes Needles Thin Wall, Sterile 22g x 1' 1 per pack Expired [DATE] -(1) box Needles Thin Wall, Sterile 22g x 1' 1 per pack Expired [DATE] -(2) boxes 4-non-coring needles 20g 90 degree (1.00 in/2.5 centimeters (cm)) Expired [DATE] -(1) 3 ml syringe with hypodermic safety needle 25g x ,d+[DATE]' Expired [DATE] -(2) 3 ml syringe with hypodermic needle 25g x ,d+[DATE]' Expired [DATE] -(1) 3 ml 25 g x ,d+[DATE]' 3 milliliters (ml) hypodermic safety needle Expired [DATE] -(2) 25g x 1 (0.5 millimeters x 125mm) BD Safety Glide Needle Expired [DATE] -(1) bottle of ProSource Nocarb Expired [DATE] -(6) Cavilon Advanced Skin Protectant Expired [DATE] <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-(3) Test swabs Expired [DATE]</p> <p>-(1) Intermittent Catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag) Uncoated 16 in 14 French (fr) Expired [DATE]</p> <p>-(1) 14 fr urethral red rubber catheter Expired [DATE]</p> <p>-(2) Long straight tip male 16 in/40 cm fr 14 Expired [DATE]</p> <p>-(3) 14 fr Tri-Flo Suction Cath-N-Glove Kit Expired [DATE]</p> <p>-(1) Box of Hemocult Single slide test-Expired [DATE]</p> <p>-(1) Bottle of Resident R73's 12.5 mg Hydrochlorothiazide (medication used to treat high blood pressure) Expired [DATE]</p> <p>-(1) bottle of Resident R73's 240 mg Verapamil (medication used to treat high blood pressure) Expired [DATE]</p> <p>-(1) bottle of Resident R73's 40 mg Atorvastatin Calcium (medication used to lower cholesterol) Expired [DATE]</p> <p>-(1) bottle of Resident R73's 10 mg Memantine (used to treat moderate to severe Alzheimer's disease) Expired [DATE]</p> <p>During an interview on [DATE], at 2:43 p.m. the Director of Nursing confirmed the facility failed to properly store medications in one out of two medications rooms (Wellstep) and failed to properly store a medication on one of four medications carts (2nd Floor Middle Hall Medication Cart).</p> <p>28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services.</p> <p>28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services.</p>

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on facility policy, observations, and staff interviews it was determined that the facility failed to provide adaptive feeding devices for one of four residents (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility policy Assistive Devices dated 8/30/24, indicated any assistive equipment/devices will be available to any resident for whom equipment would be beneficial in assisting the resident's ability to maintain or improve current function.</p> <p>Review of the admission record indicated Resident R1 admitted to the facility on [DATE], and readmitted [DATE].</p> <p>Review Resident R1's active physician order dated 8/4/21, indicated the resident is to have a blue inner lip plate with meals.</p> <p>Review of Resident R1's MDS dated [DATE], indicated the diagnoses of encephalopathy (a disease that affects brain structure or function), aphasia (a disorder that affects language and communication), and epilepsy (a brain condition that causes recurring seizures.)</p> <p>During an observation on 10/8/24, at 12:12 p.m. Resident R1's lunch was observed on the meal cart in a Styrofoam container.</p> <p>During an interview and observation on 10/8/24, at 12:18 p.m. Nurse Aide, Employee E10 confirmed the facility failed to provide Resident R1 with his blue inner lip plate for lunch.</p> <p>During an interview on 10/9/24, at 12:04 p.m. the Director of Nursing confirmed the facility failed to provide adaptive feeding devices for one of four residents (Resident R1).</p> <p>28 Pa Code: 211.6(a) Dietary service.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577</p> <p>Based on a review of facility policy, observation, and staff interview, it was determined that the facility failed to properly maintain kitchen equipment and unit pantries in a sanitary condition creating the potential for cross contamination and food-borne illness (Main Kitchen, [NAME] Court, and [NAME] Court).</p> <p>Findings include:</p> <p>A review of facility policy Food Storage dated 8/30/24, indicated that food storage areas shall be maintained in a clean, safe, and sanitary manner.</p> <p>During an observation on 10/7/24, at 10:11 a.m., of the walk-in dairy cooler in the main kitchen, conducted with Dining Services Director (DSD) Employee E1, revealed that the cold air condenser fan covers (6 total) and the ceiling immediately forward of these cooler fans had a build-up of dust, grime, and debris. DSD Employee E1 confirmed observation by surveyor when viewed.</p> <p>During an observation on 10/8/24, at 10:20 a.m., on the [NAME] Court Nursing Unit, revealed 3 blue gel cold therapy ice packs were found in the Resident Food Pantry area freezer.</p> <p>During an interview on 10/8/24, at 10:23 a.m., Licensed Practical Nurse (LPN) Employee E2 confirmed that blue gel cold therapy ice packs should not be stored with food in the Resident Food Pantry freezer.</p> <p>During an observation on 10/9/24, at 11:35 a.m., on the [NAME] Court Nursing Unit, revealed 2 blue gel cold therapy ice packs were found in the Resident Food Pantry area freezer.</p> <p>During an observation and interview on 10/9/24, at 11:40 a.m., with the Assistant Director of Nursing (ADON) Employee E3, who confirmed that ice packs should not be stored in Resident Food Pantry freezers, creating the potential for cross-contamination and food-borne illness.</p> <p>During an interview on 10/11/24, at 1:15 p.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to properly maintain kitchen equipment and unit pantries in a sanitary condition creating the potential for cross contamination and food-borne illness (Main Kitchen, [NAME] Court, and [NAME] Court).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577</p> <p>Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to obtain a physician order for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for three of four residents (Resident R55, R84, and R119).</p> <p>Findings include:</p> <p>Review of the facility policy Hospice Communication dated 8/30/24, indicated the facility will communicate with hospice providers throughout the course of a resident's care. Communication will be done quarterly in conjunction with the care plan and PRN (as needed) based upon resident specific issues. Documentation of stated communication will be reflected in the resident medical record.</p> <p>Review of Resident R55's clinical admission record indicated that he was admitted to the facility 6/11/24, with diagnoses of vascular dementia (a condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain. It causes problems with reasoning, planning, judgment, and memory), respiratory failure, and benign prostatic hyperplasia (a condition in which the flow of urine is blocked due to the enlargement of the prostate gland).</p> <p>Review of Resident R55's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 9/26/24, indicated diagnoses remain current upon review. Section O-0110 Special treatments indicated an x for hospice services.</p> <p>Review of Resident R55's physician order dated 6/27/24, indicated hospice services were to be provided as of this date. Further review of Resident R55's current physician orders failed to indicate which hospice provider was providing this service and this hospice providers contact information.</p> <p>Review of Resident R55's current plan of care on 10/10/24, failed to indicate diagnosis for hospice care, which hospice provider was providing services, and providers contact information.</p> <p>During an interview of 10/10/24, at 12:20 p.m., Registered Nurse Assessment Coordinator (RNAC) Employee E4 confirmed that Resident R55's current physician orders for hospice did not indicate which hospice provider was selected and providers contact information, and that Resident R55's care plan did not include hospice diagnosis and provider information as required.</p> <p>Review of the clinical record indicated Resident R84 was admitted to the facility on [DATE], with diagnoses of Parkinson's Disease (a movement disorder of the nervous system that worsens over time), depression, and intellectual disabilities.</p> <p>Review of Resident R84's MDS assessment dated [DATE], indicated diagnoses were current.</p> <p>Review of a physician order dated 12/6/23, indicated to refer Resident R84 to hospice for Parkinson's Disease.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R84's care plan on 10/9/24, indicated the resident has a terminal condition. Interventions indicated to refer to hospice agency and/or pastoral care interventions for end-of-life preparation.</p> <p>Review of Resident R84's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system.</p> <p>During an interview on 10/9/24, at 10:15 a.m. Unit Manager, Registered Nurse, Employee E16 confirmed Resident R84 did not have a hospice name or contact information located in the resident's care plan or order.</p> <p>Review of Resident R119's clinical admission record indicated that she was admitted [DATE], with diagnoses of dementia and cachexia (complex syndrome associated with underlying illness, causing on going muscle loss).</p> <p>Review of Resident R119's MDS assessment dated [DATE], indicated diagnoses remain current upon review. Section O-0110 Special treatments indicated an x for hospice services.</p> <p>Review of Resident R119's current active physician orders as of 10/11/24, failed to indicate an order for hospice services to include diagnosis for hospice care, hospice provider, and contact information for provider.</p> <p>Review of Resident R119's current plan of care on 10/10/24, failed to indicate diagnosis for hospice care, which hospice provider was providing services, and providers contact information.</p> <p>During an interview on 10/11/24, at 10:34 a.m., RNAC Employee E4 confirmed that Resident R119's current physician orders did not include an order for hospice care, and that Resident 119's care plan did not include hospice diagnosis and provided information as required.</p> <p>During an interview on 10/11/24, at 1:15 p.m., the Nursing Home Administrator confirmed the facility failed to obtain a physician order for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of- life care for three of four residents (Resident R55, R84, and R119).</p> <p>28 Pa Code: 211.12 (d)(3)(5) Nursing services</p>		

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NAME OF PROVIDER OR SUPPLIER St John Specialty Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Wittenberg Way Mars, PA 16046	

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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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46336</p> <p>Based on review of facility policy, infection control documentation and staff interview, it was determined that the facility failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for two of ten months (September and October 2024).</p> <p>Findings include:</p> <p>Review of facility policy Infection Control Program dated 8/30/24, indicated the program, surveillance, and prevention for infection control practices are the responsibility of the Infection Preventionist and the Committee.</p> <p>Review of the Center for Disease Control and Prevention How to Safely Remove Personal Protective Equipment (PPE) dated 10/3/22, indicated all PPE is removed before exiting the patient room except a respirator, if worn. Remove the respirator after leaving the patient room and closing the door. It was indicated gloves, goggles or face shield, and gown must be removed and discarded in a waste container.</p> <p>During an observation on of a dressing change on 10/8/24, at 10:41 a.m. Registered Nurse, Employee E21 exited Resident R16's room, who was in isolation for COVID, with her gloves and gown.</p> <p>Review of infection control documentation for the previous ten months (January - October 2024) failed to reveal surveillance for tracking infections for residents and staff for two of ten months (September and October 2024).</p> <p>During an interview on 10/9/24, at 1:33 p.m. the Director of Nursing confirmed the facility failed to implement an effective infection control plan as required for the months of September and October 2024 and was unable to produce the documents.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</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>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER St John Specialty Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Wittenberg Way Mars, PA 16046	

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>46336</p> <p>Based on review of the facility's infection control policies and procedures and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program for two of ten months (September and October 2024).</p> <p>Findings include:</p> <p>Review of facility policy Infection Control Program dated 8/30/24, indicated review of designated microbiological reports; review antibiotic usage, antibiotic susceptibility/resistance, and trend studies.</p> <p>Review of the facility's Infection Control surveillance for January - October 2024, failed to include documentation to indicate that antibiotic monitoring was completed for two of ten months (September and October 2024).</p> <p>During an interview on 10/9/24, at 1:33 p.m. the Director of Nursing confirmed that the facility failed to implement an antibiotic stewardship program that included a system of surveillance to monitor antibiotic use and lab correlation for infections for two of ten months and was unable to produce the tracking records for September and October 2024.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</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>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER St John Specialty Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Wittenberg Way Mars, PA 16046	
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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 0942</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents.</p> <p>46167</p> <p>Based on review of facility documents and staff interview, it was determined that the facility failed to provide training on resident rights for one of five staff members (Employee E7).</p> <p>Findings include:</p> <p>Review of facility policy Staff Education dated 8/30/24, indicated that staff will complete yearly mandatory education requirements. Required education includes Resident Rights.</p> <p>Review of the facility provided staff list indicated that Nurse Aide (NA) Employee E7 was hired on 1/7/16. Review of NA Employee E7's facility provided training record did not include training on resident rights.</p> <p>During an interview on 10/10/24, at 9:02 p.m. Nursing Home Administrator confirmed that the facility failed to provide training on resident rights for one of five staff members.</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa Code: 201.18 (b)(1) Management.</p> <p>28 Pa Code: 201.20 (a)(c) Staff development.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>46167</p> <p>Based on review of facility documents, employee education records, and staff interview, it was determined that the facility failed to provide training on QAPI (Quality Assurance and Performance Improvement) for one of five staff members (Employee E7)</p> <p>Findings include:</p> <p>Review of facility policy staff education dated 8/30/24, indicated that staff will complete yearly mandatory education requirements. Required education includes QAPI.</p> <p>Review of the facility provided staff list indicated that Nurse Aide (NA) Employee E7 was hired on 1/7/16. Review of NA Employee E7's facility provided training record did not include training on QAPI.</p> <p>During an interview on 10/10/24, at 9:02 p.m. Nursing Home Administrator confirmed that the facility failed to provide training on QAPI for one of five staff members.</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa Code: 201.18 (b)(1) Management.</p> <p>28 Pa Code: 201.20 (a)(c) Staff development.</p>