

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Yorkview Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 970 Colonial Avenue York, PA 17403	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 37817 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for one of 34 residents reviewed (Resident 5). Findings include: Review of Resident 5's clinical record documented diagnoses that included sleep apnea (a sleep disorder in which breathing repeatedly stops and starts), heart failure (the heart doesn't pump blood as it should), and respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide). Review of Resident 5's physician orders included BiPAP (a bilevel positive airway pressure machine - a type of ventilator that helps people breathe by delivering pressurized air into their lungs through a mask) minimum 5, maximum 20, PS 4-8 (unit of measure) with 2 Liters oxygen bleed, in at bedtime, with a start date of June 2, 2022. Review of Resident 5's annual MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental, or psychosocial needs) assessment dated May 2, 2024, and quarterly MDS assessments dated March 18, 2024; February 16, 2024; and November 6, 2023, failed to document use of a noninvasive ventilator. During an interview with Employee 20 (Registered Nurse Assessment Coordinator) on June 6, 2024, at 10:55 AM, it was revealed that Resident 5's aforementioned assessments should've been coded for use of a noninvasive ventilator. During an interview with Nursing Home Administrator on June 6, 2024, at 11:02 AM, it was revealed that the aforementioned assessments should've been coded correctly. 28 Pa. Code 211.5 Medical records		

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

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

TITLE

(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 33305 Based on staff interviews, facility policy review, and clinical record review, it was determined that the facility failed to ensure that a comprehensive, person-centered care plan was developed for three of 34 residents reviewed (Residents 12, 142, and 163) . Findings include: Review of facility policy, titled Care Plans, Comprehensive Person-Centered, with a last revised date of September 2022, revealed the following: 1) The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person centered care plan for each resident; 8) h. incorporate identified problem areas; and 10) identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. Review of Resident 12's clinical record revealed diagnoses that included vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain) and paroxysmal atrial fibrillation (a fast irregular heartbeat that last a few hours or days). Review of Resident 12's physician orders revealed an order for apixaban (an anticoagulant [blood thinning] medication) oral tablet five milligrams by mouth two time a day. Review of Resident 12's comprehensive plan of care failed to reveal focus areas for Resident 12's diagnosis of dementia and use of anticoagulant medication. During an interview on June 6, 2024 at 9:49 AM, with the Nursing Home Administrator (NHA) and Director of nursing (DON), the DON revealed Resident 12's comprehensive plan of care had been updated to include focus areas for dementia and use of anticoagulant medication. The DON stated that it was the facility's expectation that comprehensive care plans be developed accurately and timely. A review of the clinical record for Resident 142 on June 4, 2024, at 9:00 AM, revealed diagnoses that included type 2 diabetes mellitus (a form of diabetes that is characterized by high blood sugar, insulin resistance, and relative lack of insulin) and hypertension (elevated blood pressure). Review of Resident 142's current physician orders revealed that the Resident was receiving two types of insulin (Novolog and Insulin glargine) since April 2024. A review of Resident 142's current care plan failed to reveal a care plan for type 2 diabetes mellitus. During an interview with the DON on June 6, 2024, at 1:00 PM, the DON agreed that Resident 142 should be care planned for type 2 diabetes mellitus. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record for Resident 163 on June 4, 2024, at 9:00 AM, revealed diagnoses that included atrial fibrillation (irregular and rapid heartbeat) and and type 2 diabetes mellitus. Review of Resident 163's current physician orders revealed that the Resident was receiving coumadin (a blood thinner to treat and prevent clots). During an interview with the DON on June 6, 2024, at 1:00 PM, the DON agreed that Resident 163 should be care planned for atrial fibrillation and receiving a blood thinner. Further review of Resident 163's record revealed the Resident had a fall on May 21, 2024, and sustained a large hematoma to her right forehead and scalp area. The Resident was transferred to the hospital where a wound bandage was applied to the open area of the hematoma (a collection of blood outside of a blood vessel that can occur due to trauma or injury). On May 23, 2024, the physician documented to continue to monitor the hematoma. A review of Resident 163's care plan on June 4, 2024, failed to include the fall, monitoring of the hematoma, or any wound care. During an interview with the DON on June 6, 2024, at 1:00 PM, the DON agreed that Resident 163 should be care planned for monitoring and care of the hematoma. 28 Pa. Code 211.12 (d)(5) Nursing services		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 37817 Based on observations, review of clinical records, and resident and staff interviews, it was revealed that the facility failed to provide necessary individualized services to maintain Activities of Daily Living (ADL- wash face, brush teeth, eating, brush hair) regarding fingernail care for one of 34 residents reviewed (Resident 110). Findings include: Review of Resident 110's clinical record revealed diagnoses that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), macular degeneration in both eyes (an eye disease that causes vision loss), anxiety (a feeling of worry, nervousness, or unease), and dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory and abstract thinking). Observation on June 3, 2024, at 10:43 AM, revealed Resident 110's fingernails on both hands were long and jagged. During an interview with Resident 110 on June 3, 2024, at 10:43 AM, it was revealed that he is offered a shower once a week; however, he prefers to wash up at his sink in his room, and that he does receive assistance from the staff. It was also revealed that he would like his fingernails trimmed, or an Emery board (flat long object with emery paper used for fingernail and toenail care) so he can do it himself. During an interview with Employee 6 (Licensed Practical Nurse) it was revealed that Resident 110 will refuse showers an times, he is very private, and hygiene is difficult. Review of Resident 110's bathing tasks on June 6, 2024, at 9:16 AM, revealed the Resident was scheduled for showers on Thursday evening shift. No showers or baths were documented as provided over the past 30 days, however, there were documented Resident refusals on May 16th and 30th, 2024. Observation and interview regarding Resident 110's fingernail with Employee 6 on June 3, 2024, at 11:09 AM, the Resident agreed to have them trimmed after lunch. Review of Resident 110's care plan failed to document rejection of care. Review of Resident 110's quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) dated April 5, 2024, failed to document rejection of care, and documented the Resident as independent with bathing. Review of progress notes April 6th through June 6th, 2024, failed to document rejection of care. (continued on next page)		

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

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Nursing Home Administrator on June 4, 2024, at 2:03 PM, it was revealed that Nursing Assistants should trim fingernails during scheduled showers. It was also revealed that Resident 110 tends to refuse care, and that refusal of care should be documented. 28 Pa. Code 211.12 Nursing Services		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305 Based on review of the clinical record, observations, and staff and resident interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for two of 34 residents reviewed (Residents 140 and 163). Findings include: Review of Resident 140's clinical record revealed diagnoses that included malignant neoplasm of the colon (colorectal cancer, is a cancerous tumor that develops in the colon or rectum) and diabetes (a chronic disease that occurs when the pancreas does not produce enough insulin). Observation of Resident 140 on June 2, 2024, at 10:45 AM, revealed the Resident lying in bed. During an immediate interview with Resident 140, the Resident revealed he was on hospice. Review of Resident 140's current physician orders on June 3, 2024, failed to reveal a current physician order for Hospice care and services. Review of Resident 140's Care Plan on June 4, 2024, revealed a care plan of, Resident is receiving hospice care related to end stage illness, with a date initiated and revised of March 8, 2024. Review of facility provided hospice contracts revealed a hospice contract between the facility and Resident 140's hospice provider dated March 7, 2024. Interview with the Nursing Home Administrator (NHA) on June 5, 2024, at 9:00 AM, revealed that Resident 140 was receiving hospice services when he came to the facility on [DATE], and currently does not have any physician's orders for hospice services. Review of Resident 163's clinical record revealed diagnoses that included atrial fibrillation (irregular, rapid heart rate) and diabetes. Observation of Resident 163 on June 2, 2024, at 10:45 AM, revealed the Resident lying in bed. When asked about the bandage on her right forehead and the large area of bruising and swelling to the right side of her face, the Resident replied, I fell two weeks ago and had to go to the hospital for a CT scan (computed tomography-a medical imaging technique that uses x-rays and computers create detailed pictures of the inside of the body) and x-rays to my left shoulder. The Resident also revealed she had a fracture (broken bone) of the left shoulder. Resident also had a large hematoma (collection of blood outside of a blood vessel that can occur due to trauma and injury) of the right forehead and scalp area. On June 3, 2024, Resident 163's fall investigation report was reviewed, which verified the Resident sustained a fall out of her wheelchair when bending forward to pick something off of the floor. The fall report revealed the Resident sustained the hematoma measuring 6 cm (centimeters) by 4 cm. Neurological checks were initiated prior to the Resident being sent to the hospital, and convened on return to the facility until completed, per policy. All neurological checks were within normal limits. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further interview with Resident 163 revealed that the mesh wound dressing covering the open area of the hematoma was applied during the hospital visit on May 21, 2024. On June 6, 2024, at 7:00 AM, the facility obtained orders from the physician to remove the current dressing, cleanse the area with normal saline solution, and to apply a dry dressing every dayshift the open area of the hematoma until healed. During an interview with the NHA on June 6, 2024, the NHA stated that she would expect the staff to follow-up with the physician regarding care and treatment to the open area of the hematoma when no instructions were provided by the hospital on the discharge summary. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 40010 Based on review of facility policy, observation, and staff interview, it was determined that the facility failed to ensure the resident received care, consistent with professional standards, to prevent pressure ulcers for one of 37 residents reviewed (Resident 140). Findings Include: Review of facility policy, titled Wound Care, revised October 2010, revealed Steps in the Procedure, 1. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during the procedure on the clean field. Also, 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves. Review of Resident 140's clinical record revealed diagnoses that included pressure ulcer of left heel (skin ulcer caused by excess pressure) and diabetes (a chronic disease that occurs when the pancreas does not produce enough insulin). Observation of a dressing change to Resident 140's left heel on June 5, 2024, at 10:47 AM, revealed Employee 17 gathered dressing supplies, took them to Resident 140's room, and placed the supplies onto Resident 140's overbed table without placing a drape or washing/disinfecting the table to create a clean field. Further observation of Employee 17 revealed that, after the dressing on Resident 140's left heel was removed, Employee 17 cleansed the pressure ulcer, applied medicated ointment, and applied a clean bandage prior to washing her hands and applying new clean gloves. Further observation of Employee 17 revealed that, when the dressing change was complete, Employee 17 gathered the supplies off of Resident 140's overbed table and left the room without cleaning the overbed table. Interview with the Director of Nursing (DON) on June 6, 2024, at 11:45 AM, revealed that Employee 17 should have created a clean field to work from prior to completing the dressing change. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 37817 Based on facility policy, clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to provide a therapeutic diet, per physician's order, for two of 34 residents reviewed (Resident 74 and 137). Findings include: Review of facility Snack policy, revised July 2023, read, in part, afternoon snacks will be provided to those residents as labelled snacks per Registered Dietitian or resident request. Nourishing snack is defined as an offering of items, single or in combination, from the basic food groups. Review of facility policy Encouraging and Restricting Fluids, revised October 2010, read, in part, when a resident had been placed on restricted fluids, remove the water pitcher and cup from residents' room. Clinical record review for Resident 74 revealed diagnosis that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine). During an interview with Resident 74 on June 3, 2024, at 10:58 AM, it was revealed that she had experienced a weight loss. Review of Resident 74's weigh history documented a significant weight loss of 27 pounds in the past six months. Review of Resident 74's physician orders included consistent carbohydrate diet, mechanical soft texture, thin consistency, with a start date of December 19, 2023; and significant snack or choice in afternoon related to diabetes mellitus, with a start date of December 24, 2023. During interview with Employee 7 (Licensed Practical Nurse) on June 4, 2024, at 12:54 PM, revealed dietary staff are to put a peanut butter and jelly sandwich on Resident 74's lunch tray for an afternoon snack, but the Resident doesn't always get it. Meal observation on June 4, 2024, at 12:55 PM, Resident 74's tray ticket read, in part, consistent carbohydrate mechanical soft diet, puree vegetables, puree white bread, and yogurt. Resident 74 received ground kielbasa, puree cabbage, noodles, regular dinner roll, and yogurt on her meal tray. During an interview with Resident 74 on June 4, 2024, at 12:55 PM, it was confirmed she didn't receive a peanut butter and jelly sandwich on her meal tray. Surveyor observed that the peanut butter and jelly sandwich was not documented on ticket. During an interview with Employee 6 (Licensed Practical Nurse) on June 4, 2024, at 1:05 PM, it was revealed that Resident 74 received a grilled cheese sandwich that day on her lunch tray, and the Resident ate that in place of her meal. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of progress note dated June 4, 2024, at 1:17 PM, read, in part, the kitchen was called to order a peanut butter and jelly sandwich for the Resident's afternoon significant snack of choice. Review of Resident 74's March 2024, April 2024, and June 2024 MAR (Medication Administration Record-documentation of medications, nutritional supplements, or physician ordered snacks) failed to document the significant afternoon snack was administered at 2:00 PM on March 12th, 2024; April 4th, 2024; and June 2nd, 2024. Further clinical record review revealed no progress notes for the aforementioned dates documenting rational for not administering the significant snack. During an interview with Nursing Home Administrator (NHA) on June 5, 2024, at 12:20 PM, revealed the peanut butter and jelly sandwich was added to Resident 74's tray ticket, and staff should remove it from the lunch tray and save it for the afternoon snack. During an interview with the Director of Nursing (DON) on June 5, 2024, at 2:28 PM, it was revealed that Resident 74 should've been provided a significant afternoon snack per physician order. Review of Resident 137's clinical record documented diagnoses that included hypokalemia (low potassium in the blood) and heart failure (the heart doesn't pump blood the way it should). Review of Resident 137's June 2024 physician orders on June 3, 2024, at 1:22 PM, documented fluid restriction 2000 milliliters (ml - unit of measure) total per 24 hours, with a start date of November 31, 2023. Observation on June 4, 2024, at 10:25 AM, revealed there was a Styrofoam cup with water on Resident 137's over the bed table, with the date of June 4th. During an interview with Resident 137 on June 4, 2024, at 10:25 AM, it was revealed that he is provided a Styrofoam cup of water daily. Review of Resident 137's May and June 2024 MAR documented the fluids nursing provided with medications per shift; there weren't fluid administration guidelines for meals or medications documented. The average daily fluid intake documented by nursing of fluids provided with medications on the June MAR was between 180 ml to 720 ml per day, and on the May MAR was between 540 ml and 1440 ml per day. Review of Resident 137's meal ticket documented 2 milligram sodium diet (low sodium diet) and 1500 ml fluid restriction. Review of physician orders on June 5, 2024, at 2:26 PM, read, in part, 2000 ml fluid restriction: breakfast 540 ml, lunch 420 ml, dinner 300 ml; medication pass 240 ml each shift; each shift 2000 ml fluid restriction with meals AND every shift for 2000 ml fluid restriction with medication administration; start date June 5, 2024, at 7:00AM. During an interview with the NHA on June 5, 2023, at 2:30 PM, revealed that, prior to June 5, 2024, the volume of fluids provided by dietary and nursing should've been planned and communicated, and that the tray ticket should match the physician order. It was also revealed that fluid intake at meals was not recorded by nursing staff, only the fluids provided during medication pass. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 49123 Based on document review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents who require dialysis receive such services consistent with professional standards of practice for one of one resident reviewed for dialysis (Resident 46). Findings include: Review of the facility's Nursing Home Dialysis Transfer Agreement, read, in part, #3. Designated resident information. Facility shall ensure that all appropriate medical, social, administrative, and other information accompany all Designated Residents at the time of transfer to Center. This information shall include but is not limited to where appropriate the following: (d) Appropriate medical records, including history of the Designated Resident's illness, including laboratory and x-ray findings. (e) Treatment presently being provided to the Designated Resident, including medications and any changes in a patient's condition (physical or mental), change of medication, diet, or fluid intake. (h) Any other information that will facilitate the adequate coordination of care, as reasonably determined by Center. Review of Resident 46's clinical record revealed diagnoses that included chronic kidney disease (CKD) stage five (when the kidneys are severely damaged and can no longer filter waste from the blood) and dependence on renal dialysis (need for treatment that removes extra fluid and waste products from the blood when the kidneys are not able to). Review of Resident 46's physician orders revealed that Resident 46 was ordered to receive dialysis every Monday, Wednesday, and Friday. Review of Resident 46's dialysis communication forms revealed there were no forms for the following dates: April 1, 3, 5, 8, 10, 12, 15, 17, 19, 22, 24, 26, and 29, 2024; May 1, 3, 6, 8, 10, 13, 15, 17, 20, 22, 24, 27, 29, and 31, 2024; and June 3, 2024. During a staff interview with Employee 23 on June 5, 2024 at 11:15 AM, it was revealed that, when Resident 46 returns from dialysis, the communication form is placed in the physician's communication folder to be reviewed and signed. Review of the physician's communication folder revealed no communication forms for Resident 46. Review of documentation provided by the facility revealed that Resident 46 had received dialysis on the aforementioned dates. During an interview on June 5, 2024 at 11:34 AM, with the Nursing Home Administrator (NHA), it was revealed the facility does not have a policy for dialysis care. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on June 6, 2024 at 12:13 PM, with the Director of Nursing (DON), in the presence of the NHA, revealed the facility had called the dialysis center and obtained the missing dialysis communication forms for Resident 46 from the aforementioned dates. The DON stated that it was the facility's expectation that dialysis communication forms be obtained immediately upon the residents return to the facility. 28 Pa Code 201.18 (d) Management 28 Pa Code 211.5 (f) Clinical records 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 34631 Based on document review and staff interview, it was determined that the facility failed to complete a performance review of every nurse aide at least once every 12 months for two of five nurse aide documents reviewed (Employees 12 and 13). Findings Include: A review of Employee 12's personnel information revealed a hire date of May 13, 1991. A review of Employee 12's most recent Competency Evaluation revealed a review and completion date of May 6, 2023. A review of Employee 13's personnel information revealed a hire date of April 9, 2013. A review of Employee 13's most recent Competency Evaluation revealed a review and completion date of April 5, 2023. An interview with the Director of Nursing on June 6, 2024, at 12:15 PM, revealed the evaluations provided are the most recent and additional information will be sought. After the survey, no additional information was provided to verify the completion of annual performance reviews for Employees 12 and 13 thus far in the year 2024. 28 Pa. Code 201.19 (2) Personnel policies and procedures		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 33879 Based on observations, facility policy review, manufacturer label review, and staff interviews, it was determined that the facility failed to store medications in a manner consistent with professional standards for two of five medication carts observed (300 medication cart and F Wing 2 medication cart). Findings include: Review of facility policy, titled Storage of Medications, last revised April 2007, revealed the policy statement read, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Subsection 1 stated, Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medication between containers. Further, subsection 2 stated, The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. Observation of the 300 medication cart on June 6, 2024, at approximately 11:15 AM, revealed two Lantus insulin pen (insulin delivery system), that were partially used, with no opened date. Review of the manufacturer's storage requirements revealed that Lantus insulin pens should be discarded after 28 days when in-use and non-refrigerated. Observation of the F Wing 2 medication cart on June 6, 2024, at approximately 11:40 AM, revealed a medicine cup filled approximately half-way with small, round, green tablets. During a staff interview at the time of the observation, Employee 18 (Licensed Practical Nurse) stated the pills appeared to be iron supplements, but was unsure as Employee 18 was not the one that placed them in the medicine cart. F Wing 2 cart was also found to have multiple loose pills contained in two drawers. During a staff interview on June 6, 2024, at approximately 12:00 PM, Director of Nursing (DON) revealed it was the facility's expectation that insulin pens are dated by staff when opened. Further, the DON revealed that medication carts are expected to be cleaned frequently, at least once-a-month by the nightshift nursing staff. Finally, DON revealed it was the facility's expectation that medications are contained in the manufacturer's supplied container. 28 Pa code 211.9(j.1)(5) Pharmacy services 28 Pa code 211.12(d)(1)(5) Nursing services		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 34631 Based on clinical record review, document review, observations, and resident and staff interviews, it was determined that the facility failed to provide a nutritionally adequate menu substitution for one of two meals observed (June 3rd and 4th, 2024, lunch meal) and failed to follow the menu for lunch meals observed on June 3, 2024, for one of seven resident areas observed (Rosemont Hall). Findings include: A review of the facility's planned lunch menu for June 3, 2024, included chicken tenders, dipping sauce, French fries, coleslaw, cinnamon applesauce, and assorted beverages. A review of the menu extension sheet (documentation of menu substitutions for therapeutic and altered textured diets) documented that all diets except for the finger food diet were to receive applesauce. During an interview with Employee 9 (Dietary Aide) June 3, 2024, at 2:22 PM, it was revealed that they ran out of applesauce during the F- west unit food cart and that the remaining residents were served ice cream. A review of the tray delivery schedule documented that there were two food carts delivered to A unit following the F-west food cart. During an interview with Employee 5 (Food Service Director) on June 3, 2024, at 2:23 PM, it was revealed that he wasn't told that they ran out of applesauce and that he would expect there would be a substitution provided to the residents. A review of the menu substitution log on June 3, 2024, at 2:20 PM, failed to document a substitution for applesauce. A review of the facility's planned lunch menu for June 4, 2024, included kielbasa, buttered noodles, sauteed cabbage, dinner roll, watermelon, and assorted beverages. A review of the menu extension sheet documented that puree diets (food blended to a smooth consistency) should've been served applesauce in place of the watermelon. A review of Resident 24's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment). An observation of Resident 24's lunch tray on June 3, 2024, at 12:05 PM, revealed no cinnamon applesauce, 2% milk, coffee, or hot tea, as documented to be served according to the meal ticket. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 115's clinical record revealed diagnoses that included dementia and vitamin D deficiency (a condition where there is not enough of this vitamin in your body. You need vitamin D to grow and maintain your bones). An observation of Resident 115's lunch tray on June 3, 2024, at 12:10 PM, revealed no cinnamon applesauce, 2% milk, coffee, or hot tea, as documented to be served according to the meal ticket. An immediate interview with Resident 115 revealed he was not offered any drinks and would prefer to have milk to drink with his meals. A review of Resident 58's clinical record documented diagnoses that included high blood pressure. A review of Resident 58's physician orders included a fortified foods diet, puree texture, thin consistency, with a start date of April 16, 2024, House Supplement two times a day 4 oz @ 1000, 2000 9/14/23. A review of Resident 58's tray ticket for the lunch meal on June 4, 2024, documented the Resident was to receive puree kielbasa, pureed noodles, pureed cabbage, fortified food (which was mashed potato), puree dinner roll, applesauce, milk, and coffee. Meal observation on June 4, 2024, at 1:00 PM, of Resident 58's meal tray, and confirmed by Employee 8 (Nursing Assistant) who assisted the Resident with his meal, revealed the Resident was served puree kielbasa, puree noodles, mashed potato, pureed cabbage, diced peaches, milk, and coffee; he didn't receive a puree dinner roll or applesauce. Employee 8 confirmed that she didn't serve the diced peaches to the Resident. During an interview with the Nursing Home Administrator on June 4, 2024, at 2:11 PM, it was revealed that the residents should've received food items per the extension sheet or provided an applicable substitution, as well as items that are to be served per the resident's meal tickets. 28 Pa. Code 211.6 Dietary Services		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37817 Based on review of facility policy, observations, and interviews, it was determined that the facility failed to store and serve food/beverages in accordance with professional standards for food safety in the kitchen and two of two nourishment pantries observed (B/C unit and Wedge [NAME] 1). Findings include: Review of facility policy Food Storage Areas, revised July 2023, read, in part, storage of dry items must be accurately labeled and dated. Leftover food is clearly labeled, dated, a used within three days or discarded. All refrigerators are kept clean. All food should be covered labeled and date. Frozen food should be defrosted in a refrigerator and date marked with a pull and use by date. Review of facility policy Food from Outside Sources, revised July 2023, read, in part, perishable foods will be marked with a use by date which is three days from the date that it was brought into the facility. Visitors/family members will label food and beverages with the resident's name, room number, and date. Observation in the walk-in refrigerator on June 3, 2024, at 9:42 AM, revealed one pound American cheese wrapped in plastic wrap, not date marked, and five 1-pound packages of thawed sliced turkey, not date marked with a pull date. During an interview with Employee 5 (Food Service Director) on June 3, 2024, at 9:44 AM, it was revealed that the American Cheese should be date marked once opened, and the sliced turkey should be date marked when pulled from the freezer. Observation in the reach in refrigerator on June 3, 2024, at 9:50 AM, revealed one tray with 16 dished servings of fruit that were not date marked. During an interview with Employee 5 on June 3, 2024, at 9:51 AM, it was revealed that the fruit or the tray should've been date marked. Observation in the chemical room near the dry storeroom on June 3, 2024, at 9:47 AM, revealed inside of the dustpan contained food particles. During an interview with Employee 5 on June 3, 2024, at 9:48 AM, it was revealed that the dustpan needed to be cleaned. Observation in the dry storeroom on June 3, 2024, at 9:48 AM, revealed 12 Styrofoam bowls of dry oat cereal weren't date marked. During an interview with Employee 5 on June 3, 2024, at 9:48 AM, it was revealed that the staff was still cleaning up from breakfast, and that the cereal would be date marked. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional observation on June 3, 2024, at 2:19 PM, revealed the cart with the bowls of cereal contained crumbs of raisin bran cereal and the bowls of oat cereal weren't date marked. Observation in the B/C- unit nourishment pantry on June 3, 2024, at 9:53 AM, in the freezer revealed: one open plastic cup with freezer burned orange slices; one Styrofoam cup with freezer burned orange slices; and one ham and egg croissant sandwich, not marked with a resident identifier or date. On the table next to the refrigerator, there was one 32-ounce container of butter pecan nutritional supplement that was open with contents partially removed, noted to be at room temperature to the touch, and was not date marked with an open or use by date. In the refrigerator: one plastic bag with foil wrapped chicken and corn without a resident identifier or date; one plastic container of sweet tea opened with a use by date of January 29, 2024; one plastic container of cooked broccoli not marked with a resident identifier or date; one 32-ounce container of butter pecan nutritional supplement, open with contents partially removed, and not marked with an open or use by date; one 8-ounce plastic cup of orange juice not marked with resident identifier or date; and the bottom shelf contained dried brown and red liquid. During an interview with Employee 5 on June 3, 2024, at 9:59 AM, it was revealed that resident items should be marked with a resident identifier and date, items should be date marked when opened, open nutritional supplements should be stored in the refrigerator, and the refrigerator should be cleaned. Observation in the Wedge [NAME] 1 nourishment pantry on June 3, 2024, a 10:05 AM, revealed one plastic container of Chinese takeout chicken/rice didn't contain a resident identifier or date, and one plastic container beef tacos dated June 3rd and didn't contain a resident identifier. In the freezer there was one plastic cup with a frozen milk shake that was not covered and didn't contain a resident identifier or date. During an interview with Employee 5 on June 3, 2024, it was revealed items should be securely covered and contain a resident identifier and date. During an interview with the Nursing Home administrator on June 5, 2024, at 12:17 PM, it was revealed that the items in the kitchen should be marked with a date, and the resident items should be marked with a resident identifier and date. 28 Pa. Code 211.6 Dietary Services		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 33305 Based on staff interview and document review, it was determined the facility failed to develop a water management program based on a risk analysis of the facility for the prevention, detection, and control of water-borne contaminants, such as Legionella, a bacteria that may cause Legionnaires' Disease (a serious type of pneumonia). Findings include: On June 4, 2024, the facility provided a policy, titled Legionella Surveillance and Detection, last revised September 2022. The policy focused on the signs and symptoms of Legionnaires' Disease when a resident develops pneumonia. On June 4, 2024, the facility was requested to provide their water management program that includes a water flow schematic, a documented risk analysis for areas at risk of contamination with Legionella (gram negative bacteria), and any routine preventative measures being performed that includes water temperature logs, flushing of stagnant water flow systems. The facility in response provided the Center for Disease Control (CDC) toolkit, titled Developing a Legionella Water Management Program. During an interview with the Nursing Home Administrator (NHA) on June 6, 2024, at 11:00 AM, the NHA was unable to provide a detailed water management program specific to the facility. The NHA also stated that maintenance staff was preparing a water flow schematic that was provided on June 6, 2024, at approximately 1:00 PM. The water flow schematic failed to show water flow for the facility. 28 Pa. Code 201.18(b)(1)(3) Management		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 34631 Based on observation and resident and staff interviews, it was determined that the facility failed to ensure each resident's bedside is equipped to allow for residents to call for staff assistance through a communication system for one of seven resident areas reviewed (Rosemont Hall). Findings Include: Observations on the Rosemont Hall in one room occupied by Residents 16 and 135 on June 4, 2024, at 9:24 AM, revealed no call bell cords leaving the Resident wall above the beds. Interviews with Residents 16 and 135 revealed they have no call bells available to call for staff assistance. An interview with the Nurse Aide (Employee 19) on June 4, 2024, at 9:28 AM, confirmed the lack of call bells available to Residents 16 and 135 in their room. An interview with the Nursing Home Administrator on June 5, 2024, at 11:58 AM, confirmed the room lacked call bells for Residents 16 and 135, and that the call bells were added and are now available for the Residents to contact staff for assistance as needed. 28 Pa. Code 205.67 (j) Electric requirements for existing construction		