STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395200	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Creek Healthcare and Rehabilitation Center	4850 Zuck Road Erie, PA 16506

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 48496 Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to provide resident privacy during medication administration for one of four residents reviewed (Resident R22). Findings include: Review of facility policy entitled Confidentiality of Information and Personal Privacy dated 1/5/24, indicated The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. and Access to resident personal and medical records will be limited to authorized staff . During observation of medication administration for Resident R22 on 6/26/24, at 8:01 a.m. Registered Nurse (RN) Employee E1 prepared medications for a resident from the Neighborhood 400 medication cart parked sideways in the hallway with the computer open sitting on top of the medication cart. RN Employee E1 then proceeded into the resident room to administer medications to a resident in the room. RN Employee E1 did not cover/protect resident/medication information that was revealed on the computer on top of the medication cart and was visible to those walking in the hallway. During the medication administration, RN Employee E1 was unable to view the computer on top of the medication cart parked sideways in the hallway outside of the resident room. During an interview on 6/26/24, at 8:15 a.m. RN Employee E1 confirmed that he/she left the medication cart with the computer open and did not cover/protect resident/medication information that was on the computer on top of the medication cart from anyone walking through the hallway. RN Employee E1 also confirmed that resident information is to be covered when not within view. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48496 Based on review of facility policies, manufacturer's guidelines, observations, and staff interviews, it was determined that the facility failed to prevent the opportunity for potential unauthorized access of medications and to appropriately discard outdated medications for two of two medication carts reviewed (Neighborhood 300 and Neighborhood 400). Findings include: Review of facility policy entitled Medication Storage in the Facility dated 1/5/24, indicated Medication rooms, carts and medication supplies are locked or attended by persons with authorized access. and Outdated, contaminated or deteriorated medications . are immediately removed from stock, disposed of according to procedures for medication disposal . Review of manufacturer's guidelines revealed that an open Insulin Lantus vial must be used within 28 days after opening or be discarded, even if the vial still contains insulin. Review of facility policy entitled Medication Administration - General Guidelines dated 1/5/24, indicated During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse . Observation of drug storage on 6/25/24, at 3:22 p.m. of the Neighborhood 400 medication cart revealed an open bottle Insulin Lantus with an open date written on it of 5/20/24. Additional observations of Neighborhood 400 medication cart revealed an open bottle of Iron Gluconate (an over the counter supplement that helps increase red blood cells) with a best-by date of 4/2024, and an open date of 6/10/24, which was beyond the best by date. During an interview on 6/25/24, at 3:22 p.m. with Licensed Practical Nurse (LPN) Employee E2 he/she confirmed that the open date on the Insulin Lantus was beyond the 28 days and should have been discarded. He/she also confirmed that the open bottle of Iron Gluconate had a manufacturer best-by date of 4/2024, which should have not been opened after the best-by date and should have been discarded. Observation of drug storage on 6/25/24, at 3:30 p.m. of the Neighborhood 300 medication cart revealed an open bottle of Iron Gluconate with a best-by date of 4/2024, and an open date of 6/1/24, which was beyond the best by date. During an interview on 6/25/24, at 3:30 p.m. with Registered Nurse (RN) Employee E3, he/she confirmed that the open bottle of Iron Gluconate had a manufacturer best-by date of 4/2024, which should not have been opened after the best-by date and should have been discarded. During observation of medication administration on 6/26/24, at 8:10 a.m. RN Employee E1 walked away and left the medication cart unattended while it was unlocked with a resident sitting approximately one foot away from the unlocked medication cart. RN Employee E1 then proceeded to walk down the hall and entered a resident room two rooms away from the medication cart, which remained unlocked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/24, at 8:13 a.m. RN Employee E1 confirmed that he/she left the medication cart unlocked that was out of his/her view when he/she was in a resident room. RN Employee E1 also confirmed that the medication cart was to be locked when out of view. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) Nursing services