

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/22/2024
NAME OF PROVIDER OR SUPPLIER  Sarah Reed Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 227 West 22nd Street Erie, PA 16502	

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 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17260</p> <p>Based on review of facility policies, clinical record review and staff interview, it was determined that the facility failed to ensure that a discharge summary, which included a recapitulation of the resident's stay and the resident's discharge status, physician's final diagnosis and prognosis or cause of death was completed for three of three closed clinical records reviewed (Residents CR94, CR95, and CR96).</p> <p>Findings include:</p> <p>A facility policy last reviewed 2/15/24, entitled Discharge Policy and Procedure indicated that a recapitulation of the resident's stay, a final summary of the resident's status and the disposition of medications would be part of the interdisciplinary summary discharge summary.</p> <p>A facility policy entitled Closed Record Policy dated 2/06/24, indicated that an interdisciplinary discharge summary is to be completed on all discharges from the facility by each member of the interdisciplinary team (IDT) and include: a short summary of resident's stay; final summary of resident status; disposition of medications; IDT on current caseload to sign off with specific instructions; physician's discharge prognosis, discharge diagnosis, cause of death, physician's signature- as applicable; and the summary goes to medical records with the chart.</p> <p>Resident CR94's closed clinical record revealed an admitted [DATE], with diagnoses that included diabetes (condition related to inadequate insulin and high blood sugars), high blood pressure and heart disease.</p> <p>Resident CR94's clinical record revealed the resident was discharged from the facility on 1/2/24. Further review of Resident CR94's clinical record, lacked evidence of a discharge summary having been completed which included a recapitulation of the resident's stay and a final summary of the resident's status.</p> <p>During interview on 3/22/24, at 10:10 a.m. the Director of Nursing (DON) confirmed that Resident CR94's closed clinical records lacked evidence of a discharge summary being completed.</p> <p>Resident CR96's closed clinical record revealed an admitted [DATE], with diagnoses including a broken rib, altered mental status, cognitive communication deficit, and difficulty speaking.</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 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Departmental progress notes revealed that Resident CR96 ceased to breath on 2/13/24, at the facility.</p> <p>Resident CR96's closed clinical record revealed that the physician's discharge summary was incomplete and did not include a cause of death.</p> <p>Resident CR95's closed clinical record revealed an admitted [DATE], with diagnoses including dyspnea (shortness of breath), surgery on the circulatory system, and acquired absence of lung.</p> <p>Departmental progress notes revealed that Resident CR95 discharged from the facility on 2/14/24.</p> <p>Resident CR95's closed clinical record revealed that the physician's discharge summary was incomplete and did not include a recapitulation of stay or reason for discharge.</p> <p>During an interview on 3/22/24, at 11:05 a.m. the DON confirmed that Resident CR96's physician's discharge summary was incomplete and did not include the cause of death and that Resident CR95's discharge summary was incomplete and did not include a recapitulation of stay or reason for discharge from the facility.</p> <p>28 Pa. Code 211.5(d)(f)(xi) Medical records</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40832</p> <p>Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure that the contracted pharmacist provided separate, written reports of irregularities identified during the medication regimen review (MRR) for one of five residents reviewed for unnecessary medications (Resident R49).</p> <p>Findings include:</p> <p>A facility policy entitled, Medication Regimen Review and Reporting dated 2/06/24, indicated that findings/recommendations of interim (routine interval) MRR are communicated to the Director of Nursing (DON) or designee and medical director, and that the findings are documented and filed with other consultant pharmacist recommendations in the resident's chart.</p> <p>Resident R49's clinical record revealed an admitted [DATE], with diagnoses including left-sided paralysis post stroke, Type 2 Diabetes (condition of improper insulin levels and blood sugar control), heart failure, irregular heartbeat, and dementia.</p> <p>Resident R49's progress notes revealed MRR's were completed monthly and lacked evidence that documented findings/recommendations/irregularities were communicated to the DON or designee and medical director, and filed with other consultant pharmacist recommendations in the resident's chart.</p> <p>During an interview on 3/21/24, at 12:38 p.m. the DON confirmed there was no evidence that the pharmacist provided irregularities on a separate, written report sent to the medical director and DON for Resident R49.</p> <p>28 Pa. Code 211.12(d)(1)(3)(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48496</p> <p>Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to provide a clinical rationale and duration for the continued use of a PRN (as needed) psychotropic (affecting the mind) medication beyond 14 days for two of five residents reviewed (Residents R34 and R50).</p> <p>Findings include:</p> <p>A facility policy entitled Psychotropic Medication Policy dated 2/6/24, indicated that, PRN orders for psychotropic drugs are limited to 14 days. The attending physician or prescriber may extend the order beyond 14 days if he/she believes the order is appropriate. The prescriber must document the rational and duration when extending the order. PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident.</p> <p>Review of Resident R34's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), anxiety disorder (a disorder that causes a person to be nervous, uneasy, or worried about something or someone), and hypertension (high blood pressure).</p> <p>Review of Resident R34's clinical record revealed a physician's order to administer Lorazepam (anti-anxiety medication), 0.5 milligrams (mg) by mouth every 24 hours PRN for anxiety and lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days.</p> <p>Review of a pharmacy recommendation form revealed an order for Lorazepam 0.5 mg every 24 hours PRN which lacked a rational and a duration for the medication.</p> <p>Review of Resident R50's clinical record revealed an admitted [DATE], with diagnoses that included, dementia, hypertension, and traumatic brain injury (a serious condition that affects the brain's function because of a sudden impact or penetration to the head).</p> <p>Review of Resident R50's clinical record revealed a physician's order dated 2/9/24, to administer Lorazepam 0.5 mg by mouth every four hours PRN for anxiety and lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days.</p> <p>Further review of Resident R50's clinical record revealed a physician's order dated 2/9/24, to administer Haloperidol (anti-psychotic) 0.5 mg by mouth every four hours PRN for agitation and lacked evidence that the resident was evaluated by the attending physician or prescribing practitioner. There also lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days.</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 3/21/24, at 12:54 p.m. the Nursing Home Administrator and Employee E1 confirmed that Resident R34's Lorazepam order and Resident R50's Lorazepam and Haloperidol orders lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days. They also confirmed that Resident R50 was not evaluated by the attending physician or prescribing practitioner for the continuation of an anti-psychotic medication.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47356</p> <p>Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to ensure that food was stored in accordance with standards for food safety and sanitation in the walk-in freezer located in the main kitchen.</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Refrigerated And Frozen Storage dated 2/6/2024, indicated that, The Food Service Department shall receive all food products in a manner that assures safety and quality of food products. All food items shall be placed on shelves and not on floor of refrigerator or freezer.</p> <p>Observations made during the initial kitchen tour on 3/19/2024, at approximately 11:00 a.m. revealed that there were several food items on the floor in the walk-in freezer located in the main kitchen.</p> <p>Interview conducted with the Food Service Director at that time confirmed the food items should not be on the floor in the walk-in freezer.</p> <p>28 Pa. Code 211.6(f) Dietary services</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p>