

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The		STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37116</p> <p>Based on observations, 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 11 of 38 residents reviewed (Residents 6, 7, 17, 43, 67, 74, 80, 83, 85, 109, and 142).</p> <p>Findings include:</p> <p>Review of Resident 6's clinical record revealed diagnoses that included atherosclerotic heart disease of the native coronary artery (cardiovascular disease involving plaque buildup in artery walls) and urinary tract infection (UTI - infection of any part of the urinary system).</p> <p>Review of Resident 6's current physician orders revealed an order to admit her to hospice services (medical services, emotional support, and spiritual resources for people who are in the last stages of a terminal illness), effective September 6, 2024.</p> <p>Review of Resident 6's September 9, 2024, significant change comprehensive 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) revealed that it was not coded to indicate that Resident 6 had received hospice services while at the facility.</p> <p>During an interview with the Nursing Home Administrator (NHA) on September 25, 2024, at 2:37 PM, he confirmed that Resident 6's September 9, 2024, MDS was coded incorrectly and was being amended.</p> <p>Review of hospital discharge paperwork dated September 3, 2024, revealed that Resident 6 was diagnosed with and treated for a UTI while hospitalized .</p> <p>Review of Resident 6's September 9, 2024, significant change comprehensive MDS revealed that this assessment was not coded to indicate that Resident 6 had a UTI in the prior 30 days.</p> <p>During an interview with the NHA on September 26, 2024, at 1:10 PM, he confirmed that the MDS was coded in error, and that a correction was underway.</p> <p>Review of Resident 7's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and history of falling.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 7's August 21, 2024, Annual MDS, revealed in Section J. Health Conditions that the Resident was coded as having one fall with no injury since their prior Quarterly MDS completed on August 3, 3024.</p> <p>Review of Resident 7's clinical record failed to reveal any documentation that the Resident had experienced a fall between August 3 and 21, 2024.</p> <p>During an interview with the NHA and Employee 1 (Regional Director of Clinical Services) on September 26, 2024, at 1:24 PM, Employee 1 confirmed that Resident 7 had not experienced any falls during the aforementioned timeframe and that the MDS was coded in error. The NHA also confirmed the MDS was coded in error and indicated he would expect a resident's MDS to be coded accurately.</p> <p>Review of Resident 17's clinical record revealed diagnoses that included repeated falls, delusional disorder (a mental health condition characterized by unshakable beliefs in something that's untrue), and muscle weakness.</p> <p>Review of Resident 17's Quarterly MDS with ARD (assessment reference date- last day of the assessment period) of August 23, 2024, revealed under P0100. Physical Restraints, H. Other, was coded as used less than daily.</p> <p>Observations of Resident 17 throughout the day on September 23, 2024, failed to reveal use of a physical restraint.</p> <p>During an email correspondence with the NHA and Employee 1 on September 24, 2024, at 11:10 AM, the surveyor requested information if Resident 17's MDS was coded accurately for use of restraint.</p> <p>Follow-up interview with the NHA on September 25, 2024, at 10:42 AM, revealed Resident 17's aforementioned MDS assessment was coded inaccurately for use of a physical restraint.</p> <p>Review of Resident 43's clinical record revealed diagnoses that included post-traumatic stress disorder (PTSD- a mental health condition that develops following a traumatic event, characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations) and repeated falls.</p> <p>Review of Resident 43's Admission MDS with ARD of April 4, 2024, revealed it was marked No under active diagnoses - PTSD.</p> <p>During an interview with Employee 7 (Registered Nurse Assessment Coordinator) on September 26, 2024, at 12:13 PM, she revealed Resident 43's MDS assessment was coded inaccurately as she was admitted with a diagnosis of PTSD.</p> <p>Follow-up interview with the NHA on September 26, 2024, at 1:15 PM, revealed he would expect resident's MDS assessments to be coded accurately.</p> <p>Review of Resident 67's clinical record revealed diagnoses that included anxiety disorder (intense, excessive, and persistent worry and fear) and fibromyalgia (chronic condition that causes widespread pain and tenderness).</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident 67's clinical record revealed Resident 67 was admitted to the facility on [DATE], and a smoking evaluation was completed.</p> <p>Review of the smoking evaluation revealed Resident 67 used tobacco products and could smoke independently.</p> <p>Review of Resident 67's admission MDS dated [DATE], revealed that it was not coded to indicate that Resident 67 currently used tobacco.</p> <p>During an interview with the NHA on September 26, 2024, at 12:53 PM, he confirmed that Resident 67's September 9, 2024, MDS was coded incorrectly, and that it was the facility's expectation MDS assessments be accurate.</p> <p>Review of Resident 74's clinical record revealed diagnoses that included hypertension (high blood pressure) and bradycardia (slow heart rate).</p> <p>Review of Resident 74's comprehensive care plan revealed the following interventions for a pressure ulcer focus area: pressure reducing wheelchair cushion, with an initiation date of February 12, 2021, and pressure reduction mattress, with an initiation date of July 14, 2019.</p> <p>Review of Resident 74's clinical record revealed a task for pressure reducing device bed, which was checked off as being in use daily for the past 30 days; as well as a task for pressure reducing device chair, which was checked off as being in use daily for the majority of the past 30 days.</p> <p>Review of Resident 74's MDS dated [DATE], revealed that Section M1200. Skin and Ulcer/Injury Treatments, A. Pressure reducing device for chair, and B. Pressure reducing device for bed, were both marked No, indicating they have not been in use with Resident 74 during the look back period.</p> <p>During an interview with the NHA on September 25, 2024, at 1:45 PM, he revealed that a Modification MDS assessment has been initiated to reflect Resident 74 had a pressure reducing device for chair and bed during the look back period on the MDS dated [DATE].</p> <p>Review of Resident 80's clinical record revealed diagnoses that included dementia and hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting left non-dominant side.</p> <p>Further review of Resident 80's clinical record revealed that the Resident had their stroke prior to their admission to the facility on [DATE].</p> <p>Review of Resident 80's Physical Therapy Evaluation and Plan of Treatment dated September 23, 2024, revealed that Resident 80 has no limited range of motion to their lower extremities because of their prior stroke.</p> <p>Review of Resident 80's Occupational Therapy Evaluation and Plan of Treatment dated July 23, 2024, revealed that Resident 80 has had a limitation in their left upper extremity since the Resident experienced their stroke.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 80's March 15, 2024, Quarterly MDS, in Section GG. Functional Abilities and Goals revealed that the Resident was coded as having no range of motion impairments.</p> <p>Review of Resident 80's June 28, 2024, Quarterly MDS that the Resident was coded as having limited range of motion to both their upper and lower extremities on one side.</p> <p>During an interview with the NHA and Employee 1 on September 26, 2024, at 10:39 AM, the NHA confirmed that there were some coding errors and that modifications were being completed. He further indicated that he would expect a resident's MDS assessment to be coded accurately.</p> <p>Review of Resident 83's clinical record revealed diagnoses that included chronic kidney disease stage 4 (the kidneys are moderately or severely damaged and are not working as well as they should to filter waste from the blood) and major depressive disorder (a serious mental disorder that affects how a person feels, thinks, and acts. It's characterized by a depressed mood, loss of interest in activities, and other symptoms that last for at least two weeks).</p> <p>Review of Resident 83's quarterly MDS dated [DATE], revealed in Section K0520. Nutritional Approaches, D. Therapeutic Diet, that Resident 83 has not received a therapeutic diet in the previous 7 days while a resident.</p> <p>Review of Resident 83's current physician's orders on September 24, 2024, revealed an order for Liberal Renal diet, Regular texture, Thin consistency, with a start date of March 23, 2024.</p> <p>Interview with the NHA on September 26, 2024, at 11:35 AM, revealed that Resident 83's MDS completed on August 23, 2024, was marked in error and that Resident 83 had received a therapeutic diet on the 7 days prior to the MDS.</p> <p>Review of Resident 85's clinical record revealed diagnoses that included dementia and PTSD.</p> <p>Review of Resident 85's current physician orders revealed that the Resident had an order for an antipsychotic medication, dated May 22, 2024.</p> <p>Review of Resident 85's clinical record revealed a psychiatric visit note dated June 25, 2024, that indicated that a gradual dose reduction (GDR) of their antipsychotic medication was clinically contraindicated.</p> <p>Review of Resident 85's July 16, 2024, Quarterly MDS, revealed in Section N. Medications that the date for physician documented clinically contraindication for a GDR was May 28, 2024.</p> <p>During an interview with the NHA and Employee 1 on September 26, 2024, at 1:23 PM, the NHA confirmed that Resident 85's MDS was coded in error and that modification would be completed. He further indicated that he would expect a resident's MDS assessment to be coded accurately.</p> <p>Review of Resident 109's clinical record revealed diagnoses that included frontotemporal neurocognitive disorder (result of damage to neurons in the frontal and temporal lobes of the brain) and unsteadiness on feet (gate disorder or postural instability).</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident 109's clinical record revealed that he was a lateral admission to the facility on [DATE], and Resident 109 had been receiving hospice services prior to being transferred.</p> <p>Additional review of Resident 109's clinical record revealed that, at the time of admission, Resident 109 had a physician's order for a soft padded helmet to be worn at all times and to be released every two hours.</p> <p>Review of Resident 109's admission MDS, dated [DATE], revealed that the facility failed to code Resident 109's MDS to reflect hospice services and the use of a restraint.</p> <p>During an interview with the NHA on September 25, 2024 at 2:17 PM, he confirmed that Resident 109's August 30, 2024, MDS was coded incorrectly, and that it was the facility's expectation MDS assessments be accurate.</p> <p>Review of Resident 142's clinical record revealed diagnoses that included bipolar disorder (a mental health condition that causes extreme mood swings from depression to mania or hypomania) and diabetes mellitus (a metabolic disorder in which the body has high sugar levels for prolonged periods of time).</p> <p>Review of Resident 142's physician orders revealed an order for Olanzapine Oral Tablet 15 mg, give 15 mg by mouth at bedtime for depression, with a start date of July 27, 2024.</p> <p>Review of Resident 142's Quarterly MDS with ARD of August 2, 2024, and Modification of Quarterly MDS with ARD of August 2, 2024, he was marked No for bipolar disorder.</p> <p>During an interview with Employee 7 on September 26, 2024, at 12:16 PM, she revealed the MDS assessment was coded inaccurately as the Olanzapine was added for bipolar depression.</p> <p>Follow-up interview with the NHA on September 26, 2024, at 1:15 PM, revealed he would expect resident's MDS assessments to be coded accurately.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>33305</p> <p>Based on policy review, resident observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for seven of 38 residents reviewed (Residents 7, 80, 85, 96, 124, 142, and 171), and failed to give the opportunity to participate in the development, review, and revision of his/her care plan for one of 38 residents reviewed (Resident 61).</p> <p>Findings include:</p> <p>Review of facility policy, titled Care Planning - Interdisciplinary Team , last reviewed August 2024, revealed that each resident has the right to participate in choosing treatment options and must be given the opportunity to participate in the development, review, and revision of his/her care plan.</p> <p>Review of Resident 7's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and hypertension (high blood pressure).</p> <p>Observation of Resident 7 on September 23, 2024, at 10:35 AM, revealed the presence of reddish-purplish discoloration to bilateral thighs and posterior calves.</p> <p>Review of Resident 7's physician orders revealed an order for fluconazole oral suspension reconstituted 40 MG (milligrams)/ML (milliliter) give 3.8 ml by mouth one time a day every Friday for yeast for four weeks, dated September 6, 2024.</p> <p>Review of Resident 7's care plan failed to reveal a focus area for their fungal infection.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Employee 1 (Regional Director of Clinical Services) on September 26, 2024, at 12:15 PM, Employee 1 indicated that Resident 7's care plan was revised to reflect their fungal infection. The NHA confirmed that the care plan should have been revised when the fungal infection was identified.</p> <p>Review of Resident 61's clinical record revealed diagnoses that included muscle weakness (decreased strength in muscles) and major depressive disorder (persistent feeling of sadness and loss of interest and can interfere with your daily life).</p> <p>During an interview with Resident 61 on September 23, 2024, at 9:48 AM, revealed she has never been invited to care plan meetings.</p> <p>Review of Resident 61's clinical record revealed her most recent care plan review date was on August 12, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the NHA on September 26, 2024, at 10:27 AM, revealed that Resident 61 did not receive a care plan invitation for the care plan meeting held on August 12, 2024.</p> <p>Review of Resident 80's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting left non-dominant side.</p> <p>Further review of Resident 80's clinical record revealed that the Resident was diagnosed with an urinary tract infection (UTI) on September 21, 2024.</p> <p>Review of Resident 80's physician orders revealed an order for ciprofloxacin hydrochloride tablets 500 mg give one tablet by mouth two times a day related to UTI for five days, dated September 21, 2024.</p> <p>Review of Resident 80's care plan failed to reveal a focus area for their UTI.</p> <p>During an interview with the NHA and Employee 1 on September 25, 2024, at 11:15 AM, Employee 1 indicated that Resident 80's care plan was revised yesterday to reflect their UTI. The NHA confirmed that the care plan should have been revised when the UTI was identified.</p> <p>Review of Resident 85's clinical record revealed diagnoses that included dementia and post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event with triggers that can bring back memories of the trauma accompanied by intense emotional and physical reactions).</p> <p>Review of Resident 85's physician orders revealed an order for Do Not Resuscitate dated August 29, 2024.</p> <p>Review of Resident 85's completed POLST (Pennsylvania Orders for Life Sustaining Treatment) form dated August 29, 2024, revealed that if Resident 85 was found with no pulse and not breathing, resuscitative measures were not to be rendered and comfort measures were to be maintained.</p> <p>Review of Resident 85's care plan revealed a care plan focus for resident has an advanced directive of Full Code [full resuscitative efforts], with a last revised date of June 3, 2020.</p> <p>During an interview with the NHA and Employee 1 on September 26, 2024, at 10:41 AM, the NHA confirmed that Resident 85's care plan should have been revised when the order changed on August 29, 2024.</p> <p>Review of Resident 96's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), delusional disorder (type of psychotic disorder; a delusion is an unshakable belief in something that is untrue), and unspecified psychosis (severe mental condition in which thought and emotions are so affected that contact can be lost with reality).</p> <p>Observation of Resident 96 on September 23, 2024, at 1:35 PM, revealed the presence of a wound dressing to their left lower leg.</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>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>48484</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to implement resident-directed care and treatment consistent with the resident's physician orders and plan of care for one of 35 residents reviewed (Resident 142).</p> <p>Findings include:</p> <p>Review of Resident 142's clinical record revealed diagnoses that included bipolar disorder (a mental health condition that causes extreme mood swings from depression to mania or hypomania) and diabetes mellitus (a metabolic disorder in which the body has high sugar levels for prolonged periods of time).</p> <p>Review of Resident 142's physician orders revealed the following physician orders:</p> <p>Insulin Lispro Subcutaneous Solution Pen-injector 200 unit /ml (Insulin Lispro) Inject as per sliding scale: if 0 - 149 = 0 units or if not eating; 150 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351+ = 12 units, notify MD if BS (blood sugar) >400, subcutaneously three times a day, with a start date of September 1, 2024, and discontinued September 12, 2024.</p> <p>Insulin Lispro Subcutaneous Solution Pen-injector 200 unit /ml (Insulin Lispro) Inject as per sliding scale: if 0 - 149 = 0 units or if not eating; 150 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351+ = 12 units Notify MD if BS >400, subcutaneously before meals, with a start date of September 12, 2024, and discontinued September 20, 2024.</p> <p>Review of Resident 142's clinical record revealed his blood sugar was greater than 400 on September 6, 10 and 16, 2024.</p> <p>Further review of Resident 142's clinical record failed to reveal documentation to indicate the physician was notified of the elevated blood sugar levels per orders.</p> <p>During an interview with Employee 1 (Regional Director of Clinical Services), in the presence of the Nursing Home Administrator, on September 26, 2024, at 12:24 PM, she revealed she was unable to locate documentation to indicate the MD was notified of the elevated blood sugars on the aforementioned dates, and she would expect physician orders to be followed.</p> <p>28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395223	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The		STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011	

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>47966</p> <p>Based on policy review, clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection for one of four residents reviewed for pressure ulcers (Resident 74).</p> <p>Findings include:</p> <p>Review of the facility policy, titled Skin and Wound Management System, last reviewed on August 2024, revealed that residents identified with skin impairments will have appropriate interventions, treatment, and services implemented to promote healing and impede infection.</p> <p>Review of Resident 74's clinical record revealed diagnoses that included hypertension (high blood pressure) and bradycardia (slow heart rate).</p> <p>Review of Resident 74's comprehensive care plan revealed a focus area for the Resident being at risk for skin integrity pressure, revised on July 16, 2024; and an intervention for heel list suspension boots when in bed, initiated on August 26, 2024.</p> <p>Observation of Resident 74 on September 23, 2024, at 9:42 AM, revealed Resident 74 was lying in bed, with the heel boots in the corner of their room, not on the Resident.</p> <p>Observation of Resident 74 on September 24, 2024, at 12:14 PM, revealed Resident 74 was lying in bed, with the heel boots in the corner of their room, not on the Resident.</p> <p>Observation of Resident 74 on September 24, 2024, at 1:16 PM, revealed Resident 74 was lying in bed, with the heel boots in the corner of their room, not on the Resident.</p> <p>Observation of Resident 74 on September 25, 2024, at 9:47 AM, revealed Resident 74 was lying in bed, with the heel boots in the corner of their room, not on the Resident.</p> <p>Review of Resident 74's clinical record revealed a task for heel list suspension boots: prevalon boots: place boots on bilateral feet for pressure reduction, which has been checked as being in use daily for the past 30 days.</p> <p>During an interview with the Nursing Home Administrator on September 26, 2024, at 10:26 AM, he revealed they are in the process of getting an order for heel boots validated for Resident 74 and, once it is validated, he would expect heel boots to be on the Resident.</p> <p>28 Pa. Code 211.12(d)(1)(3)(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** 48484</p> <p>Based on clinical record review, review of facility investigation documentation, and staff interviews, it was determined that the facility failed to ensure that each resident received adequate supervision and assistance to prevent accidents for one of 35 residents reviewed (Resident 63).</p> <p>Findings Include:</p> <p>Review of Resident 63's clinical record revealed diagnoses that included schizoaffective disorder, bipolar type (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, and mania), abnormal posture, and muscle weakness.</p> <p>Review of select facility report detailing the incident that occurred on June 27, 2024, read, in part:</p> <p>Incident Description:</p> <p>Nursing Description:</p> <p>I [Employee 4 (Registered Nurse)] was standing in the hallway down a little bit from [Resident 63's] room and [Employee 8 (Nurse Aide)] was standing there talking to me. She walked away and walked towards [Resident 63's] room, as she was walking she looked in the room, she stopped walking, turned around, and said to me 'please come help' I walked over, when I entered [Resident 63's] room, she was on the floor, supine position, directly in front of her wheelchair holding her neck and her head up off the floor. She was awake and alert, and aside from being on the floor- she did not appear to be in any acute distress. Her wheelchair was directly in from of [roommate's] bed facing the window. She was lying on the floor in the same direction as the chair, as if she just slid right off the seat on to the floor. After talking with staff, I found out that resident was just returned to her room not long before the incident. Her chair was close to the door, and call light, which was on the bed, was not within reach. She did have appropriate footwear on, sneakers- no injuries were noted. All areas of skin intact, no bumps/bruises or abrasions noted. Wheels on chair were locked.</p> <p>Immediate Action Taken:</p> <p>Description:</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>Resident assisted off of the floor by myself and three other staff members- 4 total. [Employee 10 (Nurse Aide), Employee 8, and another Employee 9 (Nurse Aide)] all helped put the resident back into bed. Bed was put in the lowest position, and call bell was placed within resident's reach. After verifying [Resident 63] knew how to use it, I spoke with staff who I know intended to put her in bed but walked away briefly due to the time (shift change) and emphasized the importance of always ensuring resident has their call bell in reach whenever they are in the room alone. Also discussed how [Resident 63] should not be left in the chair unsupervised at this time until reevaluated by [occupational therapy/physical therapy] to see if current chair is appropriate or if resident needs a different chair. Resident representative notified; medical doctor notified.</p> <p>Further review of the report revealed under Was call bell in place? Can resident use it? was marked no and further stated couldn't reach- positioned too far away from call bell/positioned close to door. Under was resident left unattended inappropriately? It was marked yes and further stated should have been positioned close to call bell and provided with call bell before being left alone. Also, under Indicate what may have caused the accident revealed The resident was left in her chair. Should have been placed in bed at the very least provided with call bell. Signed by Employee 4.</p> <p>Review of Resident 63's care plan revealed a focus area of The resident is at risk for falls, last revised March 14, 2024, with an intervention for be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Provide a prompt response to all requests for assistance, last revised on November 11, 2021.</p> <p>During an interview with the Nursing Home Administrator (NHA) on September 26, 2024, at 10:07 AM, the surveyor requested if there was any additional information to provide surrounding the incident or additional facility response to the incident such as comprehensive staff education.</p> <p>Follow-up interview with the NHA on September 26, 2024, at 1:18 PM, revealed he has nothing further in writing to provide surrounding the fall incident, and that based on the statement from Employee 4 she provided on the spot education to staff. The surveyor revealed the concern with accident hazards and supervision surrounding the incident. No further information was provided.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>33305</p> <p>Based on observations, clinical record review, interviews, and facility policy review, it was determined that the facility failed to ensure that one of 38 residents reviewed were monitored for acceptable parameters of weight (Resident 124).</p> <p>Findings Include:</p> <p>Review of facility policy, titled Weight Assessment and Intervention, last reviewed August 21, 2024, revealed: The nursing staff will measure resident weight on admission, and then weekly for four weeks. If no weight concerns are noted at this point, weights will be measured monthly thereafter or as per Dietician or MD.</p> <p>A review of the clinical record for Resident 124 revealed diagnoses that included psychosis (a mental disorder characterized by a disconnection from reality) and dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability).</p> <p>Further review of the clinical record for Resident 124 revealed a 34-pound weight loss (-15.32 % loss) between July 17, 2024, and August 17, 2024.</p> <p>A review of the recorded monthly weights indicated no weight was obtained in June 2024 and, as of September 22, 2024, no September weight was obtained.</p> <p>8/17/2024 09:56 188.0 Lbs. Sitting</p> <p>7/17/2024 05:51 222.0 Lbs. Sitting</p> <p>5/7/2024 12:30 235.6 Lbs. Sitting</p> <p>4/5/2024 08:59 235.2 Lbs. Sitting</p> <p>3/4/2024 13:12 238.4 Lbs. Sitting</p> <p>1/8/2024 13:29 236.6 Lbs. Sitting</p> <p>12/21/2023 13:36 231.8 Lbs. Sitting</p> <p>11/8/2023 08:30 246.0 Lbs. Sitting</p> <p>10/6/2023 09:22 244.8 Lbs. Sitting</p> <p>The most recent dietician note was dated June 26, 2024, and stated the following: Added routine snacks BID (twice a day) between meals as a therapeutic intervention to support nutritional status d/t poor/varied intake at meals. Will continue to monitor and adjust interventions as needed.</p> <p>A review of the physician note date August 21, 2024, stated weight was reviewed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The		STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011	

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of physician orders on September 24, 2024, for Resident 124 had the following pending order: Weekly Weights every day shift every Sun with an effective date of September 29, 2024.</p> <p>During an interview with Nursing Home Administrator (NHA) and Regional Director of Clinical services on September 26, 2024, at 10:38 AM, the Regional Director believed the weight loss documented included use of diuretics.</p> <p>At approximately 2:15 PM, on September 26, 2024, the NHA provided three staff witness statements that indicated the Resident often refuses weights. The NHA confirmed that the Resident was not care planned for refusals and the documentation in the clinical record did not reflect that he refused weight in June 2024 or September 2024.</p> <p>28 Pa. Code 201.14(a)Responsibility of licensee</p> <p>28 Pa. 211.6(a)Dietary services</p>

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NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The		STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011	
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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>48484</p> <p>Based on facility policy 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 and failed to maintain complete and accurate records related to dialysis communication for one of two residents reviewed for dialysis (Resident 158).</p> <p>Findings include:</p> <p>Review of facility policy, titled End stage renal disease, Care of a Resident with, last revised January 2019, read, in part, Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Examples of education and training of staff may include: The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis as required; Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed and may include: How information will be exchanged between the facilities. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care.</p> <p>Review of Resident 158's clinical record revealed diagnoses that included ESRD (failure of kidney function to remove toxins from blood), hypertension (elevated/high blood pressure), and diabetes mellitus (a form of diabetes that is characterized by high blood sugar, insulin resistance, and relative lack of insulin).</p> <p>Review of Resident 158's care plan revealed a focus area of Resident has hemodialysis with the potential for infection, fluid volume excess/deficit, pain, trauma ESRD, with an intervention for Dialysis and No venipuncture/blood pressures in extremity with shunt (dialysis access), initiated on January 24, 2024.</p> <p>Review of Resident 158's dialysis communication sheets provided revealed there were missing communication sheets on January 26, 2024; February 2, 9, 12, 14, and 21, 2024; April 26, 2024; and May 20 and 31, 2024.</p> <p>Further review of Resident 158's dialysis communication sheets provided failed to reveal the following: pre- or post- dialysis weights on June 21, 2024, and July 5, 2024; post-dialysis weights on May 1, 2024, and June 3, 2024; and a pre-dialysis weight on July 29, 2024.</p> <p>Review of Resident 158's blood pressure measures revealed blood pressures were documented in his arm with his dialysis access (left arm) 73 times since his admission to the facility January 23, 2024.</p> <p>Interview with Employee 1 (Regional Director of Clinical Services), in the presence of the Nursing Home Administrator (NHA), on September 26, 2024, at 10:08 AM, revealed they are unable to locate the missing communication sheets or missing documentation from the reviewed communication sheets.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The		STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011	
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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Follow-up interview with the NHA on September 26, 2024, at 1:15 PM, revealed the documentation of blood pressures taken in the left arm are inaccurate, as staff do not take Resident 158's blood pressure in his left arm. He further revealed he would expect dialysis communication sheets to be available and nursing documentation to be accurate.</p> <p>28 Pa code 211.5(f) Medical records</p> <p>28 Pa Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48484</p> <p>Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for one out of 35 residents reviewed (Resident 43).</p> <p>Findings include:</p> <p>Review of Facility Policy, titled Care Plans- Comprehensive Person-Centered, last revised September 2022, read, in part, Trauma-informed care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.</p> <p>Review of Resident 43's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included post-traumatic stress disorder (PTSD- a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things).</p> <p>Review of Resident 43's clinical record revealed an Admission Social Services Evaluation dated April 26, 2024, that noted Resident 43 has a diagnosis of PTSD related to being verbally abused by her former male roommate, with a noted trigger of raising voice.</p> <p>Review of Resident 43's care plan failed to reveal a comprehensive care plan related to PTSD.</p> <p>Interview with Employee 3 (Licensed Practical Nurse) on September 26, 2024, at 9:22 AM, revealed she was unaware of any triggers Resident 43 has related to past trauma.</p> <p>During an interview with Employee 1 (Regional Director of Clinical Services) in the presence of the Nursing Home Administrator (NHA) on September 26, 2024, at 10:09 AM, she revealed the process for identifying residents in need of trauma informed care is a social worker assessment upon admission and development of a care plan. She further revealed Resident 43 should have had a care plan developed related to her PTSD including any triggers, and since it was not developed that is why staff was not aware of her past trauma and identified trigger.</p> <p>During an interview with Employee 5 (Social Worker) on September 26, 2024, at 11:35 AM, she revealed social service assessments for newly admitted residents are typically completed within three days, and that Resident 43's admission assessment probably got missed as she was following-up with another assignment at the time.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The		STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011	
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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Employee 1 and the NHA on September 26, 2024, at 1:16 PM, the surveyor revealed the concern with the lack of a trauma informed care approach for Resident 43. No further information was provided.</p> <p>28 Pa Code 211.10 (a) Resident care policies</p> <p>28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>46253</p> <p>Based on review of select facility personnel documentation and staff interview, it was determined that the facility failed to ensure that nurse aide performance evaluations were completed at least annually for four of five nurse aides reviewed (Employees 11, 12, 13, and 15).</p> <p>Findings Include:</p> <p>Review of personnel information revealed that Employee 11's hire date was August 20, 2001; Employee 12's hire date was November 28, 2005; Employee 13's hire date was April 7, 2010; and Employee 15's hire date was January 11, 2022.</p> <p>Further review of personnel information for Employees 11, 12, 13, and 15, failed to reveal that annual performance reviews were completed.</p> <p>During an interview with the Nursing Home Administrator on September 26, 2024, at 12:35 PM, he acknowledged that he had no additional documentation to provide for the selected employees. He confirmed that he would expect annual performance reviews to be completed annually around an employee's date of hire.</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 201.19(2) Personnel policies and procedures</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>47966</p> <p>Based on facility documentation review, policy review, clinical record review, and staff interview, it was determined that the facility failed to provide pharmaceutical services to ensure a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate accounting of controlled drugs when acquiring, receiving, dispensing, and or administering to identify possible diversion for one of three residents reviewed (Resident 177).</p> <p>Findings include:</p> <p>Review of facility policy, titled Disposal of Medications and Medication-Related Supplies, last reviewed August 2024, revealed the medication disposition form is kept with the medications for return until picked up by the pharmacy; the receiving pharmacy representative signs the form to indicate receipt and gives the yellow copy to a nurse representative.</p> <p>Review of Resident 177's clinical record revealed diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks) and hypertension (high blood pressure).</p> <p>Review of Resident 177's clinical record revealed they passed away in the facility on August 9, 2024.</p> <p>Review of Resident 177's medication disposition record form provided by the Nursing Home Administrator (NHA) on September 26, 2024, at 1:10 PM, revealed the following instructions on the form: An entry is required for each medication along with the reason for disposition, signature of the person completing the form and witness if medication is being destroyed by facility or agency staff. Once the pharmacy representative has signed this form and accepted the medication to be returned, retain the yellow copy for facility or agency record and send the white copy with the medications.</p> <p>Further review of Resident 177's medication disposition record form that was dated August 10, 2024, included the following medications: Trazadone, Fluoxetine, Lisinopril, and Risperidone. The form failed to include any signatures.</p> <p>During an interview with the NHA on September 26, 2024, at 1:10 PM, he revealed he did not have any further information to provide and would expect Resident 177's medication disposition form to have been signed.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The		STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011	
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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 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>46253</p> <p>Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents were free of unnecessary psychotropic medications for one of four residents reviewed (Resident 96).</p> <p>Findings include:</p> <p>Review of facility policy, titled Antipsychotic Medication Use, with a last revised date of December 2016 and a last review date of August 21, 2024, indicated, 17. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician: a. General/anticholinergic: constipation, blurred vision, dry mouth, urinary retention, sedation; b. Cardiovascular: orthostatic hypotension [form of low blood pressure that happens when standing after sitting or lying down]; arrhythmias [abnormal heart rhythm; c. Metabolic: increase in total cholesterol/triglycerides, unstable or poorly controlled blood sugar, weight gain; and d. Neurologic: Akathisia [a movement disorder causing a feeling of restlessness and an inability to stay still], dystonia</p> <p>[unintentional sustained muscle contractions leading to abnormal postures], extrapyramidal effects [involuntary and uncontrollable movement disorders caused by certain drugs, especially anti-psychotic drugs], akinesia [loss of ability to move your muscles independently]; or tardive dyskinesia [a neurological syndrome that results in involuntary and repetitive body movements], stroke or TIA [transient ischemic attack- a short period of symptoms similar to those of a stroke caused by a brief blockage of blood flow to the brain].</p> <p>Review of Resident 96's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), delusional disorder (type of psychotic disorder; a delusion is an unshakable belief in something that is untrue), and unspecified psychosis (severe mental condition in which thought and emotions are so affected that contact can be lost with reality).</p> <p>Review of Resident 96's physician orders revealed an order for risperidone (a medication used to treat certain psychiatric conditions) 0.25 milligrams give two tablets twice a day, dated July 3, 2024.</p> <p>Review of Resident 96's care plan failed to reveal their use of an antipsychotic medication.</p> <p>Review of Resident 96's clinical record failed to reveal any documentation that the Resident was being monitored for side effects related to the use of their ordered antipsychotic medication.</p> <p>During an interview with the Nursing Home Administrator on September 26, 2024, at 12:16 PM, he confirmed that side effect monitoring for Resident 96 should have been implemented when the Resident was ordered the antipsychotic medication.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Gardens at West Shore, The		STREET ADDRESS, CITY, STATE, ZIP CODE 770 Poplar Church Road Camp Hill, PA 17011	

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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>28 Pa. Code 211.12(d)(1)(2)(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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48484</p> <p>Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to store food and utilize equipment in accordance with professional standards for food service safety in the main kitchen and five of five pantries.</p> <p>Findings include:</p> <p>Review of facility policy, titled General Food Preparation and Handling, last revised [DATE], read, in part, Procedure: The kitchen is kept neat and orderly. The kitchen and equipment are clean. All food service equipment should be cleaned, sanitized, dried, and reassembled after each use.</p> <p>Observation in the main kitchen on [DATE], at 9:31 AM, revealed Employee 2 (Food Service Director) tested the sanitizer concentration of the three-compartment sink with test strips that expired [DATE].</p> <p>Observation of the floor in the main kitchen next to the three-compartment sink on [DATE], at 9:32 AM, revealed the floor was heavily soiled with a black and grey sludge.</p> <p>Observation in the main kitchen on [DATE], at 9:33 AM, revealed the sugar and rice bins were not labeled and dated, and the flour bin was dated [DATE].</p> <p>Observation of the [DATE] refrigerator/freezer temperature log for the ,d+[DATE] unit pantry area on [DATE], at 9:35 AM, revealed temperatures failed to be logged during AM on [DATE], ,d+[DATE], ,d+[DATE], 18, 21, and 22; and PM on [DATE]-22.</p> <p>Observation of the [DATE] refrigerator/freezer temperature log for the [DATE] unit pantry area on [DATE], at 9:38 AM, revealed temperatures failed to be logged during AM and PM on [DATE]-22.</p> <p>Further observation in the refrigerator of the [DATE] unit pantry area on [DATE], at 9:39 AM, revealed a red substance spilled all throughout the bottom of the refrigerator.</p> <p>Observation of [DATE] refrigerator/freezer temperature log for the AACU unit pantry area on [DATE], at 9:41 AM, revealed temperatures failed to be logged during AM on [DATE]-12 and ,d+[DATE]; and PM on [DATE]-22.</p> <p>Observation of [DATE] refrigerator/freezer temperature log for the ACU unit pantry area on [DATE], at 9:44 AM, revealed temperatures failed to be logged during AM on [DATE]-11 and ,d+[DATE]; and PM on [DATE]-22.</p> <p>Further observation in the freezer of the ACU unit pantry area on [DATE], at 9:46 AM, revealed a red substance spilled in the freezer.</p> <p>(continued on next page)</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>Observation of [DATE] refrigerator/freezer temperature log for the 1300 unit pantry area on [DATE], at 9:50 AM, revealed temperatures failed to be logged during AM on [DATE], and ,d+[DATE]; and PM on [DATE]-22.</p> <p>Interview with the Food Service Director on [DATE], at 9:52 AM, revealed that it has been difficult to get staff to consistently log temperatures in the pantries. He further revealed the food storage bins in the kitchen should be labeled and dated, routinely cleaned and relabeled, and the kitchen and pantries should be kept clean.</p> <p>Interview with the Nursing Home Administrator on [DATE], at 11:23 AM, revealed it was the facility's expectation that the food storage bins and kitchen equipment are utilized in accordance with professional standards and the kitchen and pantries are kept clean.</p> <p>28 Pa. Code 211.6(f) Dietary services</p>		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305</p> <p>Based on observations, clinical record review, policy review, and staff interviews, it was determined that the facility failed to maintain a safe and sanitary environment that supports infection prevention and control for three of 38 residents reviewed (Residents 15, 32, and 171).</p> <p>Findings include:</p> <p>A review of the facility policy, titled Enhanced Barrier Precautions, last revised April 2024 states the following:</p> <p>Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents.</p> <p>Policy Interpretation and Implementation</p> <p>1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents.</p> <p>2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.</p> <p>a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room).</p> <p>b. Personal protective equipment (PPE) is changed before caring for another resident.</p> <p>c. Face protection may be used if there is also a risk of splash or spray.</p> <p>3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:</p> <p>a. dressing;</p> <p>b. bathing/showering;</p> <p>c. transferring;</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. providing hygiene;</p> <p>e. changing linens;</p> <p>f. changing briefs or assisting with toileting;</p> <p>g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and</p> <p>h. wound care (any skin opening requiring a dressing).</p> <p>Review of Resident 15's clinical record revealed diagnoses that included obstructive uropathy (structural or functional hindrance of normal urine flow) and hypertension (elevated blood pressure).</p> <p>Observation on September 22, 2024, revealed no signage indicating that Resident 15 was receiving enhanced barrier precautions (EBP) for the colonization of ESBL (extended spectrum beta-lactamase-enzymes produced by bacteria) that was diagnosed in October 2022.</p> <p>During an interview with the Nursing Home Administrator (NHA) on September 26, 2024, the NHA agreed that EBP should have been implemented in October 2022 with the known diagnosis of colonization of ESBL.</p> <p>Review of Resident 32's clinical record revealed diagnoses that included malignant neoplasm of cerebellum (cancerous tumor of the brain) and paroxysmal atrial fibrillation (irregular rapid heart rhythm).</p> <p>Review of Resident 32's physician orders revealed orders for EBP related to wounds and wound care: sacrum pressure cleanse with normal saline, apply medical grade honey to base of the wound, secure with dry dressing, change twice daily and as needed.</p> <p>Observations made on September 25, 2024, at 9:43 AM, of Resident 32's wound care revealed Employee 16 and Employee 17 failed to don gowns while performing Resident 32's wound care and dressing change.</p> <p>During an interview with Employee 16 on September 25, 2024, at 9:53 AM, she stated that Resident 32 was only on standard precautions and only gloves needed to be worn while providing care.</p> <p>During an interview on September 25, 2024, at 2:34 PM, with the NHA it was revealed that Resident 32 is on EBP and that it is the facility's expectation that staff wear appropriate PPE.</p> <p>Review of Resident 171's clinical record revealed diagnoses that included benign prostatic hyperplasia with lower urinary tract symptoms (a condition that causes the prostate, a male reproductive gland, to grow larger than normal and prevent normal urine stream and/or prevent fully emptying the bladder when urinating) and chronic kidney disease (longstanding disease of the kidneys leading to renal failure).</p> <p>Review of Resident 171's clinical record revealed that he was admitted on [DATE], with the suprapubic catheter.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on September 22, 2024, revealed no signage indicating the Resident 171 was receiving enhanced barrier precautions for the indwelling suprapubic catheter.</p> <p>On September 24, 2024, during the survey, the Resident 171 was placed on enhanced barrier precautions.</p> <p>During an interview with the NHA on September 26, 2024, at 12:35 PM, he acknowledged Resident 171 should have been placed in enhanced barrier precautions on admission due to having the suprapubic catheter.</p> <p>28 Pa Code 201.14(a)(c)Responsibility of licensee</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>