| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395224 | A. Building<br>B. Wing | 09/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hamilton Arms Center | 336 South West End Avenue<br>Lancaster, PA 17603 |

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) |
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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to ensure accurate assessments for two of 24 residents reviewed (Residents 6 and 57).Findings include:Review of Resident 6's MDS (Minimum Data Assessment - periodic assessment of resident needs) dated August 9, 2025, under Section N0415 - High Risk Drug Classes: Use and Indication stated that Resident 6 was receiving an anticoagulant (blood thinner).Review of Resident 6 physician orders revealed no evidence that the resident was receiving an anticoagulant.Interview with the Director of Nursing on September 26, 2025, at 1:00 p.m. confirmed that Resident 6's MDS assessment was marked incorrectly.Review of Resident 57's admission MDS assessment (MDS - periodic assessment of resident care needs) dated September 1, 2025, Section N0410 - Medications Received indicated that the resident was receiving an anticoagulant (blood thinner). Further review of the clinical record revealed no evidence that the resident was receiving an anticoagulant.Interview with the Nursing Home Administrator on September 25, 2025, at 12:47 p.m. confirmed that the resident was not receiving an anticoagulant and that the MDS was coded incorrectly.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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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on review of facility policy, clinical record review, hospice records and staff interview, it was determined that the facility failed to ensure that the clinical record accurately reflected the assessment and treatment of a pressure ulcer for one of four residents reviewed (Resident 14).Review of the facility's policy titled Pressure Ulcers/ Skin Breakdowns-Clinical Protocol last reviewed April 2018 stated that '1.The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. 2. In addition, the nurse shall describe and document/report the following: a.full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue. 'Review of Resident 14 physician orders revealed an order started on September 3, 2025 ‘cleanse open areas on buttocks, apply medihoney and foam dressing, one time a day every 3 days for Wound Care'. Further review of Resident 14 clinical record revealed a skin observation assessment conducted September 3, 2025, at 9:51 p.m. that revealed open area on the coccyx.Review of Resident 14 Hospice care documentation from Caring Hospice Services revealed that weekly monitoring and treatment for a stage 2 pressure ulcer located on the coccyx was conducted on the following days: September 2, 2025; September 10, 2025; September 16, 2025, and September 25, 2025.Review of Resident 14's clinical record did not include facility documentation of the wound assessments, measurements or treatments interventions. Interview with the Director of Nursing on September 26, 2025, at 1 pm confirmed that the facility relied on hospice documentation for the status of pressure ulcer and did not document the wound and treatments in the resident's clinical record.28 Pa. Code: 211.5 (f) Clinical records28 Pa. Code: 211.12 (d) (1) (5) Nursing Services |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on review of clinical record, facility documentation, hospital record review and staff interviews, it was determined that the facility failed to ensure one of three residents reviewed received adequate supervision during care resulting in actual harm causing a right ankle nondisplaced fracture for Resident 14. Findings include: Review of Resident 14 ‘s diagnosis revealed diagnoses including other sequelae of cerebral infarction (stroke) and Hemiplegia and Hemiparesis following cerebral infraction affecting left non-dominant side (weakness and paralysis on left side of body).Review of Resident 14 ‘s care plan revealed resident Bed mobility: total assist of one, push on resident's elbow and lower leg to roll.Review of Resident 14 Quarterly Minimum Data Set - (MDS periodic assessments of resident needs) dated May 17, 2025, revealed the resident required one assist for bed mobility and care. Review of Resident 14 clinical record revealed a nursing progress note dated September 3, 2025, at 05:45, indicating CNA (Certified Nursing Assistant) reported to nurse resident fell while providing care, nurse went to the room and observed resident on the floor. Supervisor was notified and responded promptly. Resident was lying on his/her left arm, semi prone position (this is a body position where a person is lying mostly on their stomach but tilted slightly to the side) on the right side of the bed. Resident was assessed and able to tell us where [his/her] pain is and if [he/she] can move- transferred to bed by Hoyer lift (also known as a patient lift is mechanical device designed to safely transfer individuals with limited mobility). Resident sustained visible bump right side of his/her forehead, bruise on his/her left arm and complains of right ankle pain. PRN (as needed or as the situation arises) pain medication was administered and ice pack applied to right ankle. PCP (Primary Care Physician)/POA (Power of Attorney) notified. Neurochecks initiated. Resident transferred to hospital for further evaluation.Review of information dated and submitted by the facility on September 3, 2025, to the Department revealed Resident was assessed and transferred to bed by Hoyer lift. Resident sustained visible hematoma (closed wound where blood collects and fills a space inside your body because it can't flow or drain out) to right side of [his/her] forehead, bruise on [his/her] left arm and complaints of right ankle pain. PRN pain medication was administered and ice pack applied to right ankle/POA notified.Resident transferred to hospital for further evaluation. Due to right ankle pain.Review of hospital records dated September 3, 2025, revealed Resident 14 had an X-ray on right ankle. Results revealed Possible nondisplaced fractures involving the distal fibula (lower end of the thin bone near the ankle) and distal tibia (bottom end of the shin bone near the ankle). Of note there is severe diffuse osteopenia (condition where your bones are weaker than normal due to reduced bone density.Review of facility investigation into the injury revealed a witness statement from Employee 4 obtained on September 3, 2025, at 2:30 am indicating that he/she was doing rounds and rolled resist on his/her side to change him/her. She removed the brief and placed it on the floor and when she looked up to resume care the resident had rolled out of the bed and was on the floor.Interview conducted with the Director of Nursing on September 26, 2025, at 1pm confirmed staff failed to provide Resident 14 with adequate supervision during care resulting in actual harm causing a right ankle nondisplaced fracture.28 Pa. Code 201.14(a) Responsibility of Licensee28 Pa. Code 201.18(b)(1)(e)(1) Management28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on facility policy and procedure review, observations, clinical documentation review and staff interview it was determined the facility failed to label and store medications appropriately for one of three medication rooms and one of seven medication carts. (2 low and 2 high)Findings include: Review of facility policy and procedure titled Medication Labeling and Storage, revised February 2023, revealed The facility stores all medications and biologicals in locked compartments under proper temperatures.Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medications label includes at a minimum: medications name, prescribed dose, strength, expiration date when applicable, residents name, route of administration and appropriate instructions and precautions. Observation of the 2medication room on the second-floor low side revealed the thermometer in the medication refrigerator was reading 50 degrees Fahrenheit. Review of the Medication Storage Monthly Temperature Log for 2 low medication refrigerator for September 2025 revealed no temperature was logged for September1, 2, 7, 8, 11, 15, 16, 17, 20, 21, 22, and 23. The temperatures logged for September 3, 4,5, 6, 9, 10, 12, 13, 14, 18, 19, and 24 were all for 46 degrees Fahrenheit, the highest temp on the log. Observations of a medication cart on the second-floor high side on September 24, at 11:45 a.m. revealed an opened Lantus (long-acting insulin) administration pen with no date. Interview with Licensed Nursing Employee E5 at the time of the observation confirmed that the Lantus insulin should have been dated when opened. Interview with the Nursing Home Administrator and the Director of Nursing on September 24, 2025 at 12:15 p.m. confirmed opened medications should be dated and the medications refrigerator log was not completed and the high temperature in reading in the refrigerator addressed. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing Services |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, interviews with staff and record reviews it was determined that the facility failed to ensure food was stored and maintained in accordance with professional standards for food safety for five of five personal refrigerators. Findings Include:Observations of all days of the survey revealed that five residents had personal refrigerators in their rooms. Observations revealed they were no temperature logs or any evidence for monitoring or cleaning refrigerators.Interview with Nursing Home Administrator (NHA) on September 26, 2025, confirmed facility did not have a written policy for personal refrigerators. NHA stated that no education had been provided to residents or their families regarding safe food storage, refrigerator cleaning or temperature monitoring.28 Pa. Code 211.6(c) Dietary Services |