| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 395241 | A. Building<br>B. Wing | 01/17/2025 |

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| Hilltop Healthcare and Rehabilitation Center | 700 S. Cayuga Avenue<br>Altoona, PA 16602 |

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| (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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>42079<br><br>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident and/or resident representative had an opportunity to formulate an advance directive (instructions regarding the provision of health care when the resident is incapacitated) or assist in formulating an advance directive for six of 54 residents reviewed (Residents 37, 62, 81, 88, 90, 100).<br><br>Findings include:<br><br>The facility policy regarding advance directives, dated November 26, 2024, indicated that on admission the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.<br><br>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 37, dated December 18, 2024, indicated that the resident had mild cognitive impairment, was understood and able to understand others, required supervision to moderate assistance with care needs, and had diagnoses that included hemiplegia (paralysis or weakness to one side of the body due to brain injury) following a cerebral infarction (lack of blood supply to the brain resulting in brain death to parts of the brain), depression, and anxiety.<br><br>A quarterly MDS assessment for Resident 62, dated November 1, 2024, revealed that the resident was cognitively impaired, was usually understood and able to usually understand others, required supervision to moderate assistance with care needs, and had a diagnosis of dementia.<br><br>A quarterly MDS assessment for Resident 81, dated December 13, 2024, revealed that the resident was cognitively impaired, was understood and able to understand others, required assistance with some care needs, and had diagnoses that included dementia and hemiplegia/hemiparesis following a cerebral infarction.<br><br>(continued on next page) |

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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An annual MDS assessment for Resident 88, dated November 7, 2024, revealed that the resident was cognitively impaired, was understood and able to understand others, required supervision to minimal assistance with care needs, and had a diagnosis of dementia.<br><br>A quarterly MDS assessment for Resident 90, dated December 6, 2024, revealed that the resident was cognitively impaired, was understood and able to understand others, required moderate assistance with care needs, and had a diagnosis of dementia.<br><br>An annual MDS assessment for Resident 100, dated December 25, 2024, revealed that the resident was cognitively intact, was understood and able to understand others, required minimal to substantial assistance with care needs, and had a diagnosis of polyneuropathy (peripheral nerves damage throughout the body causing weakness, numbness, burning pain, and difficulty moving or feeling).<br><br>Review of the clinical records for Residents 37, 62, 81, 88, 90 and 100 revealed no documented evidence that the residents and/or their representatives were given the opportunity to formulate an advance directive, were offered assistance in formulating an advance directive, or their decision regarding an advance directive.<br><br>Interview with the Director of Nursing on January 15, 2025, at 1:31 p.m. confirmed that there was no documented evidence in Resident 37's, 62's, 81's, 88's, 90's or 100's medical records to indicate that the residents and/or resident representatives were given the opportunity to formulate an advance directive, were offered assistance in formulating an advance directive, or their decision regarding an advance directive.<br><br>28 Pa. Code 201.29(a)(d) Resident Rights. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>42079<br><br>Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to provide a clean and homelike environment in residents' rooms for one of 54 residents reviewed (Resident 8).<br><br>Findings include:<br><br>The facility's policy regarding homelike environment, dated November 26, 2024, indicated that the purpose was to provide a safe, clean, and sanitary living environment for the residents.<br><br>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated November 26, 2024, indicated that the resident was cognitively intact, was usually understood and usually able to understand others, was dependent on staff for all care needs, and had diagnoses that included quadriplegia (paralysis or weakness to both side of the body due to brain injury) and depression.<br><br>Observations of Resident 8's room on January 17, 2025, at 10:39 a.m. revealed that there was an area of broken dry wall, approximately 12 inches by 12 inches near the closet and another area of damaged dry wall that was approximately four inches by one and a half inches near the bathroom entrance. Interview with Licensed Practical Nurse 1 at the time of the observations revealed that she had reported it to the maintenance department, but he has since resigned. Interview with Resident 8 on January 17, 2025, at 10:40 a.m. revealed that he has an electric wheelchair and staff forget to put the foot rest up, and when they park the wheelchair in that area of the room the foot rest ends up hitting and scraping through the dry wall.<br><br>Interview with Maintenance Employee 2 on January 17, 2025, at 12:59 p.m. confirmed that both areas of dry wall were in need of repair and that the area was not homelike. There was no work order that he was aware of in the system, and the former director recently resigned last week.<br><br>28 Pa. Code 207.2(a) Administrator's Responsibility. |

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assure that each resident's assessment is updated at least once every 3 months.<br><br>48941<br><br>Based on review of the Resident Assessment Instrument Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that quarterly Minimum Data Set assessments were completed within the required time frame for one of 54 residents reviewed (Resident 81).<br><br>Findings include:<br><br>The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that the assessment reference date (ARD - the last day of the assessment's look-back period) of a quarterly MDS assessment must be no more than 92 days after the ARD of the most recent assessment of any type, and the assessment was to have a completion date (Section Z0500B) that was no later than the ARD plus 14 calendar days.<br><br>A quarterly MDS assessment for Resident 81 had an ARD of December 13, 2024, which was 116 days after the previous annual MDS assessment with an ARD of August 19, 2024.<br><br>An interview with the Director of Nursing on January 17, 2025, at 11:40 a.m. confirmed that the above referenced quarterly MDS assessment was not completed within the required time frame.<br><br>28 Pa. Code 211.5(f) Clinical Records. |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19102<br><br>Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for four of 54 residents reviewed (Residents 7, 63, 75, 85).<br><br>Findings include:<br><br>The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, revealed that Sections H0100 through H0300 were to gather information on the use of bowel and bladder appliances and urinary and bowel continence. Section H0100 was to be coded for each appliance that was used at any time in the past seven days. Select none of the above if none of the appliances A-D were used in the past seven days. Section H0400 was to be coded nine (9), not rated if during the seven-day look-back period the resident had an ostomy (a hole/stoma in the abdominal wall which allows waste to leave the body) or did not have a bowel movement for the entire seven days.<br><br>Physician's orders for Resident 7, dated February 26, 2024, included an order to change the resident's ostomy wafer every seven days on the 3-11 shift.<br><br>An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated December 6, 2024, revealed that Section H0100C was coded indicating that the resident had an ostomy. Section H0400 was coded (0) indicating that the resident was always continent of bowel function.<br><br>Interview with the Director of Nursing on January 17, 2025, at 12:52 p.m. confirmed that Section H0400 was coded inaccurately for Resident 7, who had an ostomy and should have been coded (9), not rated due to the resident having an ostomy.<br><br>The RAI User's Manual, dated October 2024, indicated that the intent of Section M was to document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions. Section M0300D was used to record the number of Stage 4 pressure ulcers the resident had. Section M0300F was to record the number of unstageable (cannot be staged due to coverage of the wound bed by slough and/or eschar) pressure ulcers that resident had. Section M1040B was to be checked if the resident had a diabetic foot ulcer.<br><br>A quarterly MDS assessment for Resident 63, dated November 6, 2024, revealed that the resident had zero Stage 4 pressure ulcers, one unstageable pressure ulcer, and had a diabetic foot ulcer.<br><br>Review of a skin and wound note for Resident 63, dated November 5, 2024, revealed that the resident had one Stage 4 pressure ulcer.<br><br>Interview with the Director of Nursing on January 17, 2025, at 11:41 a.m. confirmed that Resident 63's MDS, dated [DATE], was not accurately coded to reflect the resident's skin condition during the seven-day look-back assessment period.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | The RAI User's Manual, dated October 2024, indicated that the intent of Section N was to record the number of days during the seven days of the assessment period that any type of injection, insulin, and/or select medications were received by the resident. Section N0415C Anti-depressant medications was to be coded if the resident took the medication during the seven-day look-back period.<br><br>Physician's orders for Resident 75, dated December 23, 2024, included an order for the resident to receive 50 milligrams (mg) of Trazadone (a depression pill) at bedtime. The resident's Medication Administration Record (MAR) for December 2024 revealed that the resident received Trazadone at bedtime from December 23 to 31, 2024.<br><br>An admission MDS assessment for Resident 75, dated December 29, 2024, revealed that Section N0410C indicated that the resident did not receive an antidepressant medication during the assessment period.<br><br>Interview with the Director of Nursing on January 15, 2025, at 2:32 p.m. confirmed that Section N0415C was coded inaccurately for Resident 75, who received Trazadone during the seven-day lookback period.<br><br>The RAI User's Manual, dated October 2024, indicated that the intent of Section N was to record the number of days during the seven days of the assessment period that any type of injection, insulin, and/or select medications were received by the resident. Section N0450D Anti-psychotic Medication Review was to be coded if the resident had a physician documented GDR as clinically contraindicated, (0) if a GDR has not been documented by a physician as clinically contraindicated or (1) a GDR has been documented by a physician as clinically contraindicated.<br><br>Physician's orders for Resident 85, dated October 23, 2023, included orders for the resident to receive 25 mg of Seroquel (an antipsychotic medication) twice a day and 12.5 mg of Seroquel in the afternoon for dementia with agitation and aggressive behaviors.<br><br>A pharmacy recommendation, dated June 10, 2024, questioned whether a GDR could be done at this time. The physician disagreed and indicated that the resident was stable, had a diagnosis of dementia with agitation, and no changes were to be made.<br><br>A quarterly MDS assessment for Resident 85, dated November 25, 2024, revealed that Section N0450D was coded (0), indicating that the resident did not have a GDR documented by a physician as clinically contraindicated.<br><br>Interview with the Director of Nursing on January 15, 2025, at 2:32 p.m. confirmed that Section N0450D was coded inaccurately for Resident 85.<br><br>28 Pa. Code 211.5(f) Clinical Records. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>46994<br><br>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for two of 54 residents reviewed (Residents 7, 11).<br><br>Findings include:<br><br>An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated December 6, 2024, indicated that the resident was cognitively impaired and required assistance with care needs, was taking an anticoagulant (medication that thins the blood), had an indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), and had diagnoses that included coronary artery disease (a disease that limits blood flow to the heart caused by plaque buildup in the arteries) and neurogenic bladder (bladder lacks control due to nerve or muscle problems). An anticoagulant care plan for Resident 7, dated January 23, 2023, indicated that the resident was on Coumadin (an anticoagulant) therapy related to the presence of a cardiac pacemaker (a surgically-implanted small battery-powered device to manage irregular heartbeats or heart failure). A care plan for Resident 7, dated January 22, 2024, indicated that the resident had an indwelling catheter.<br><br>Physician's orders for Resident 7, dated December 8, 2024, included an order for the resident to receive 5 milligrams (mg) of Apixaban (an anticoagulant) twice daily. Review of Resident 7's clinical record revealed that his Coumadin was discontinued on December 6, 2024.<br><br>Interview with the Director of Nursing on January 15, 2025, at 10:11 a.m. confirmed that Resident 7's care plan was not revised to reflect that the Coumadin was discontinued and that his anticoagulation therapy was changed to Apixaban.<br><br>Physician's orders for Resident 7, dated January 8, 2025, included an order for the resident to have a 16 French (size) urinary (foley) catheter (an indwelling catheter), with a 30 cubic centimeters (cc) balloon (located on the bladder end of the catheter and filled with sterile water to hold the tube in place) for neurogenic bladder.<br><br>Observations of Resident 7 on January 15, 2025, at 2:13 p.m. revealed that the resident had a foley catheter leg bag (a urine collection bag used to help maintain mobility and comfort) visible under his pants to the right thigh area.<br><br>Interview with Nurse Aide 3 at that time indicated that it was the resident's preference to have the leg bag for dignity, as he did not want the catheter bag visible to anyone. There was no documented evidence in Resident 7's care plan that indicated he used a foley catheter leg bag and that he preferred to use the leg bag for dignity.<br><br>Interview with the Director of Nursing on January 17, 2025, at 11:40 a.m. confirmed that Resident 7's care plan should have been revised to reflect his use of the foley catheter leg bag and that it was his preference to use the leg bag for dignity.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A quarterly MDS assessment for Resident 11, dated November 13, 2024, revealed that the resident was cognitively intact, required assistance with personal care needs, had an indwelling urinary catheter (a thin tube inserted into the bladder to drain urine), and had diagnoses that included intervertebral disc disorder with radiculopathy, lumbar region (conditions that affect the nerve roots in the lower back and can cause pain, numbness, and weakness in the legs) and diabetes.<br><br>Review of Resident 11's care plan, dated September 9, 2024, revealed that the resident had actual skin impairment to both of his palms, identified as surgical incisions.<br><br>A skin and wound note for Resident 11, dated September 10, 2024, at 1:17 p.m., revealed that the resident was seen for an initial weekly skin assessment because he was a new admission to the facility, and that the bilateral hands surgical that was identified on admission were scars from a previous surgery, and the resident did not need weekly assessments from the wound nurse.<br><br>An interview with the Director of Nursing on January 17, 2025, at 12:55 p.m. revealed that the surgical wounds identified in Resident 11's care plan were actually scars from previous surgeries, and his care plan should have been revised when that was identified.<br><br>28 Pa. Code 211.12(d)(5) Nursing Services. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>46994<br><br>Based on clinical record reviews, as well as staff and resident interviews, it was determined that the facility failed to ensure that residents were provided with showers as scheduled for one of 54 residents reviewed (Resident 24).<br><br>Findings include:<br><br>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated November 4, 2024, indicated that the resident was cognitively intact, was dependent on staff for bathing/showering, and had diagnosis that included chronic congestive heart failure (a long-term condition where the heart cannot pump enough blood to the body) and diabetes.<br><br>Review of Resident 24's active task list, initiated on July 31, 2024, revealed that the resident had a bathing preference for showers, and showers were scheduled to be provided every Wednesday and Sunday on dayshift.<br><br>Review of Resident 24's Bath/Shower record, dated October 2024 through December 2024, revealed that a bed bath was provided instead of a shower on October 2, 9, 13, 16, 27, and 30. Only bed baths were provided to the resident during the month of November, and bed baths were provided instead of a shower on December 4, 8, and 15.<br><br>Interview with Resident 24 on January 13, 2025, at approximately 10:15 a.m. revealed that the resident was not getting her showers as preferred because staff provided excuses for not being able to provide a shower, like no hot water was available or the shower room was too cold.<br><br>Interview with the Director of Nursing on January 15, 2025, at 3:03 p.m. revealed that there was no documented evidence that the resident was offered or refused to have a shower on her scheduled shower days when bed baths were provided instead of showers.<br><br>28 Pa. Code 211.12(d)(5) Nursing Services. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>46994<br><br>Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that physician's orders regarding treatment administration were followed for one of 54 residents reviewed (Resident 9).<br><br>Findings include:<br><br>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated October 16, 2024, revealed that the resident was cognitively intact, required assistance with personal care needs, and had diagnoses that included Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements).<br><br>Physician's orders for Resident 9, dated March 29, 2025, included an order for the resident to receive 2.5 milligrams (mg) of Midodine Hydrochloride (used to treat low blood pressure) twice a day and to hold the medication if the resident's systolic blood pressure (SBP-the top number in a blood pressure reading) is greater than 120.<br><br>Review of the Medication Administration Record (MAR) for Resident 9, dated October 2024, revealed that 2. 5 mg of Midodrine Hydrochloride was administered on October 6 at 5:00 p.m. when the resident's SBP was 124, on October 10 at 5:00 p.m. when the resident's SBP was 127, and on October 26 at 5:00 p.m. when the resident's SBP was 124. Review of the resident's MAR, dated November 2024, revealed that 2.5 mg of Midodrine Hydrochloride was administered on November 10 at 5:00 p.m. when the resident's SBP was 122, on November 22 at 8:00 a.m. when the resident's SBP was 140, and on November 24 at 5:00 p.m. when the resident's SBP was 122. Review of the resident's MAR, dated December 2024, revealed that 2.5 mg of Midodrine Hydrochloride was administered on December 12 at 5:00 p.m. when the resident's SBP was 142, on December 15 at 8:00 a.m. when the resident's SBP was 150, on December 30 at 8:00 a.m. when the resident's SBP was 126, and on December 30 at 5:00 p.m. when the resident's SBP was 127. Review of the resident's MAR, dated January 2025, revealed that 2.5 mg of Midodrine Hydrochloride was administered on January 1 at 8:00 a.m. when the resident's SBP was 129, on January 6 at 5:00 p.m. when the resident's SBP was 128, and on January 12 at 5:00 p.m. when the resident's SBP was 132.<br><br>Interview with the Director of Nursing on January 14, 2025, at 1:55 p.m. confirmed that Midodrine Hydrochloride was administered to Resident 9 on the above mentioned dates and times when is should have been held per physician's orders when the resident's SBP was greater than 120.<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing Services. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>19102<br><br>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that tube feeding residual amounts were documented per the facility's policy for one of 54 residents reviewed (Resident 70).<br><br>Findings include:<br><br>The facility's policy regarding checking gastric residual volume (GRV - the amount of fluid remaining in the stomach at a point in time during enteral nutritional feeding), dated November 26, 2024, indicated that the purpose of this procedure is to assess tolerance of enteral feeding and minimize the potential for aspiration. Staff were to aspirate the stomach contents and if the GRV was greater than 250 milliliters (mL), the physician was to be notified, and staff were to asses the resident for feeding intolerance. The person performing the procedure was to record the amount of, if any, gastric residual in the resident's medical record.<br><br>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 70, dated December 3, 2024, indicated that the resident was cognitively impaired and had an enteral feeding tube.<br><br>Physician's orders for Resident 70, dated January 9, 2025, included an order for the resident to receive feedings of Glucerna 1.2 (a tube feeding formula that contains 1.2 calories in every milliliter) at 75 cubic centimeters (cc's) per hour, and physician's orders, dated January 15, 2025, included an order for the resident to receive feedings of Glucerna 1.5 at 65 cc's per hour. Both orders included that staff were to check the residual volume every shift and if there was more than 250 mL of GRV, staff were to withhold further feedings and recheck in one hour. The physician was to be notified if the GRV was more than 250 mL on the second check. If the GRV was greater than 500 mL, staff were to withhold the feeding and notify the physician.<br><br>A review of Resident 70's clinical record for January 1 through January 17, 2025, revealed that there was no documented evidence of the amount of gastric residuals that were checked every shift per the facility policy.<br><br>Interviews with the Director of Nursing on January 17, 2025, at 1:37 p.m. confirmed that there was no documented evidence that the amount of residuals checked every shift was recorded in the resident's clinical record per the facility policy.<br><br>28 Pa. Code 211.12(d)(3)(5) Nursing Services. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>19102<br><br>Based on a review of facility policies and written menus, as well as observations and interviews with residents and staff, it was determined that the facility failed to follow their planned menu.<br><br>Findings include:<br><br>A facility policy, dated November 25, 2024, indicated that service staff will inspect food trays to ensure that the correct meal was provided to each resident.<br><br>Observations on January 13, 2025, at 11:38 a.m. of Resident 100 in her room during lunch revealed that her tray did not have margarine on it for her roll. Interview with the resident at that time revealed that she did not want to eat a dry roll. She stated that she eats in her room and her meal trays routinely come without sugar packets, condiments, napkins, or flatware.<br><br>Interview with Nurse Aide 4 on January 13, 2025, at 1:09 p.m. confirmed that there was no margarine on any of the trays on A wing, and she called the kitchen, but there was none available.<br><br>During an interview with a group of residents on January 14, 2025, at 10:26 a.m. the residents indicated that they do not receive the correct menu or they are missing items on their trays.<br><br>The facility's written and printed menu for the lunch meal on January 13, 2025, indicated that the residents were to receive beef meatloaf with glaze, green beans, scalloped potatoes, dinner roll buttered, margarine, pound cake, and choice of beverage.<br><br>Interview with the Dietary Manager on January 13, 2025, at 2:54 p.m. confirmed that the kitchen does have margarine available. The facility does not have individual packets, but they would provide small lidded cups of margarine; however, the kitchen staff did not put it on the trays. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>19102<br><br>Based on review of policies, as well as observations and resident and staff interviews, it was determined that the facility failed to serve palatable food that was at appropriate temperatures.<br><br>Findings include:<br><br>The facility's policy regarding food service temperatures, dated November 26, 2024, revealed that meal service temperatures for hot foods were to be 140 degrees Fahrenheit (F) or above, and cold foods were to be 40 degrees F or below.<br><br>Interview with Resident 77, who was alert and oriented and able to make her needs known, on January 13, 2025, at 12:07 p.m. revealed that she eats in her room, her meal trays were served cold, and foods are overcooked and not palatable. She also does not receive all of the items on her meal ticket.<br><br>Interview with Resident 100, who was alert and oriented and able to make her needs known, on January 13, 2025, at 11:38 a.m. revealed that she eats in her room and that her meal trays are served cold and without sugar packets, condiments, napkins, or flatware.<br><br>During an interview with a group of residents on January 14, 2025, at 10:26 a.m. the residents indicated that the hot foods were not always hot when served.<br><br>Observations in the kitchen on January 15, 2025, at 12:47 p.m. revealed that a test tray was placed on the lunch meal cart going to the A wing. The cart arrived on the unit at 12:47 p.m., and the last resident was served and eating at 1:06 p.m. At 1:06 p.m. the temperature of the mashed potatoes was 129.0 degrees Fahrenheit (F) and the temperature of the mixed vegetables was 122.0 degrees F. The items were lukewarm and not hot to taste, and were not palatable at those temperatures. The temperature of the milk was 51 degrees F and not cold to taste.<br><br>Interview with the Dietary Manager on January 15, 2025, at 1:10 p.m. confirmed that foods were not served at the proper temperatures.<br><br>28 Pa. Code 201.18(b)(1) Management.<br><br>28 Pa. Code 211.6(f) Dietary Services. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>19102<br><br>Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to store food in accordance with professional standards for food service safety by failing to store food under sanitary conditions, failing to ensure that food was served under sanitary conditions, and failing to ensure that ice was made and stored in sanitary ice machines for one of one ice machines (kitchen).<br><br>Findings include:<br><br>The facility's policy regarding food labeling and dating, dated November 26, 2024, revealed that upon receipt, all items must have a received date and an expiration date, and upon opening, all items must have an open date and a use-by date.<br><br>The facility's policy regarding ice machines and ice storage, dated November 26, 2024, revealed that ice machines and ice storage/distribution containers would be used and maintained to ensure a safe and sanitary supply of ice.<br><br>The facility's procedure for washing pots and pans, undated, revealed that the staff were to check the chemical sanitizer strength and record the parts per million, and check and record the wash sink and rinse sink temperatures for each meal.<br><br>Observations in the walk-in freezer on January 13, 2025, at 8:52 a.m. and 8:58 a.m. revealed that a plastic bag of pizza crusts contained no labels or dates, and a large build up of ice was located on the outside of the freezer's condenser. A ceiling vent above the tray line in the kitchen had a large accumulation of black debris and dust on the cover, and the ice machine had a pink, removable build up on the top plastic piece and was dripping water onto the ice.<br><br>Observations in the kitchen on January 17, 2025, at 9:17 a.m. revealed that the ceiling vent above the tray line still had a large accumulation of black debris and dust on the cover. The three-compartment sink contained water, and there were utensils and pans drying on the counter; however, the sanitizer log, dated January 2025, revealed that there was no documentation of the sanitizer strength for each meal January 1 through January 17, 2025.<br><br>Interview with the Dietary Manager on January 15, 2025, at 8:52 a.m. and 8:58 a.m. and on January 17, 2025, at 9:17 a.m. confirmed that the plastic bag of pizza crusts was not labeled or dated and should have been, the build up of ice on the condenser needed taken care of, the ice machine and ceiling vent needed cleaned, and staff were not documenting the sanitizer strength when using the three-compartment sink.<br><br>28 Pa. Code 211.6(f) Dietary Services. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>48941<br><br>Based on review of the facility's plans of correction and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies.<br><br>Findings include:<br><br>The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) survey ending February 1, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending January 17, 2025, identified repeated deficiencies related to failure to maintain a homelike environment, failure to maintain accuracy of assessments, failure to update/revise care plans, failure to provide quality of care, failure to ensure food was palatable and had proper serving temperatures, and failed to ensure the food was stored, prepared/served under sanitary conditions and that utensils and dishes were cleaned and stored in sanitary conditions.<br><br>The facility's plan of correction for a deficiency regarding safe/clean/comfortable/homelike environment, cited during the survey ending February 1, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F584, revealed that the facility's QAPI failed to successfully implement their plan to ensure ongoing compliance with regulations regarding homelike environment.<br><br>The facility's plan of correction for a deficiency regarding the accuracy of assessment, cited during the survey ending February 1, 2024, revealed that facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding accuracy of assessments.<br><br>The facility's plan of correction for a deficiency regarding a failure to update/revise residents' care plans, cited during the survey ending February 1, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding updating/revising residents' care plans.<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending February 1, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care.<br><br>The facility's plans of correction for deficiencies regarding ensuring that food was palatable and at proper serving temperatures, cited during the survey ending on February 1, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F804, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding ensuring the food was palatable and had proper serving temperatures.<br><br>The facility's plan of correction for a deficiency regarding appropriate food preparation/storage/serving, cited during the survey ending February 1, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F812, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding food preparation/storage/serving and storage and cleaning of dishes/utensils.<br><br>Refer to F584, F641, F657, F684, F804, F812.<br><br>28 Pa. Code 201.14(a) Responsibility of Licensee.<br><br>28 Pa. Code 201.18(e)(1) Management. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>19102<br><br>Based on review of established infection control guidelines, facility policy, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for eight of 54 residents reviewed (Residents 7, 8, 11, 12, 34 63, 70, 80).<br><br>Findings include:<br><br>CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply.<br><br>The facility's policy regarding EBP, dated November 26, 2024, indicated that EBP's referred to the use of gown and gloves for the use during high contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). An order for EBP's will be obtained for residents with any of the following: 1) Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers), and/or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO and 2) Infection or colonization with any resistant organisms targeted by the CDC and epidemiologically important MDRO when contact precautions do not apply. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high contact resident care activities that require the use of gloves and gowns.<br><br>The facility's policy regarding hand hygiene, dated November 26, 2024, indicated that hand hygiene was the primary means to prevent the spread of infections and staff were to use an alcohol based hand rub of at 62 percent alcohol or use soap and water following after contact with blood and bodily fluids and removing gloves.<br><br>An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 7, dated December 6, 2024, indicated that the resident was cognitively impaired requires assistance with care needs, had an indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), and had a diagnosis of neurogenic bladder (bladder lacks control due to nerve or muscle problems).<br><br>Physician's orders for Resident 7, dated January 8, 2025, included an order for the resident to have a urinary (foley) catheter (an indwelling catheter) for neurogenic bladder. A care plan for Resident 7, dated January 22, 2024, revealed that the resident had an indwelling foley catheter for neurogenic bladder. A care plan for Resident 7, dated February 27, 2024, revealed that the resident had an MDRO related to a history of Extended-spectrum beta-lactamases (ESBL-a bacteria resistant to antibiotics) in the urine with an intervention for EBP, dated November 27, 2024. There was no documented evidence that EBP were implemented for Resident 7 until November 27, 2024.<br><br>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated November 26, 2024, indicated that the resident was cognitive intact, was usually understood and usually able to understand others, was dependent on staff for all care needs, and had diagnoses that included quadriplegia (paralysis or weakness to both side of the body due to brain injury) and had pressure ulcers (wound caused by pressure).<br><br>Physician's orders for Resident 8, dated January 3, 2025, included an order to cleanse the right ischium (hip) with Dakin's solution 0.25 percent (wound treatment) and dry, apply collagen particles, pack with Dakins moistened gauze, and cover with bordered gauze; cleanse the right nephrostomy site (nephro - a tube placed into the bladder through the skin to drain urine) and dry, and apply a transparent film; and cleanse the left ischium and dry, apply collagen particles and cover with bordered gauze.<br><br>Observations of wound care for Resident 8 on January 17, 2025, at 10:47 a.m. revealed that Licensed Practical Nurse 5 while wearing gloves provided incontinence care to the resident after he had a bowel movement. Licensed Practical Nurse 5 changed her gloves without performing hand hygiene and using gauze cleaned the feces from this pressure ulcer on the right ischium, then cleaned the the wound with Dakin's solution and gauze, applied collagen, and applied the Dakin soaked gauze. Then Licensed Practical Nurse 5 changed her gloves at 10:48 a.m. and used saline to clean the nephro tube on the right side and applied the dressing. The resident had another bowel movement, and incontinence care was provided. Licensed Practical Nurse 5 removed all her PPE and left the room to get more supplies. Licensed Practical Nurse 5 cleaned the left buttocks with towels and water to remove the remaining feces, changed her gloves, cleaned the second pressure ulcer, applied collagen, and applied the dressing. Before leaving the room Licensed Practical Nurse 5 washed her hands with soap and water. Interview with Licensed Practical Nurse 5 on January 17, 2025, at 12:59 p.m. revealed that she did not perform hand hygiene between glove changes and dirty and clean tasks.<br><br>Interview with the Infection Preventionist on January 17, 2025, at 1:55 p.m. confirmed that hand hygiene should have been completed between glove changes and dirty and clean tasks.<br><br>A quarterly MDS assessment for Resident 11, dated November 13, 2024, revealed that the resident was cognitively intact, required assistance with personal care needs, had an indwelling urinary catheter (a thin tube inserted into the bladder to drain urine), and had diagnosis that included intervertebral disc disorder with radiculopathy, lumbar region (conditions that affect the nerve roots in the lower back and can cause pain, numbness, and weakness in the legs) and diabetes.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Physician's orders for Resident 11 dated September 19, 2024, included for the resident to have a foley catheter for urine retention (a condition that makes it difficult or impossible to empty the bladder). There was no documented evidence that EBP were implemented for Resident 11 until November 27, 2024.<br><br>An admission MDS assessment for Resident 12, dated September 2, 2024, indicated that the resident was cognitively impaired and had a suprapubic catheter (a thin, flexible tube inserted through a small incision in the lower abdomen (pubic area) directly into the bladder).<br><br>A physician's order for Resident 12, dated October 17, 2024, included an order for the resident to have a suprapubic catheter due to neurogenic bladder (a condition where the nerves that control the bladder are damaged, leading to abnormal bladder function). There was no documented evidence that EBP were implemented for Resident 12 until November 27, 2024.<br><br>A quarterly MDS assessment for Resident 34, dated December 15, 2024, revealed that the resident was cognitively intact, required assistance with personal care needs, had an infection in her foot, and had reconstructive surgery following medical procedure and diabetes.<br><br>Observations and interview with Resident 34 on January 13, 2025, at 10:14 p.m. revealed that there was no PPE or signage posted outside of the room indicating that the resident was on transmission based precautions. Resident 34 indicated that she had methicillin-resistant staphylococcus aureus (MRSA infection that has been resistant to antibiotics), was on intravenous (IV - medication and fluids that are injected directly into a vein) antibiotic medication, and had surgery on her foot. Resident 34 currently had a wound vacuum (negative pressure wound therapy type to help wounds heal) in use.<br><br>Physician's orders for Resident 34, dated December 9, 2024, included an order for the resident to have contact isolation related to the MRSA to the right heel and staff are to ensure the wound vac was functioning and in place every shift. Current physician orders, dated January 13, 2025, included an order for the resident to have one gram of Vancomycin (antibiotic medication) intravenously one time a day for osteomyelitis (infection in the bone)<br><br>Interview with Registered Nurse 7 on January 13, 2025, at 12:28 p.m. indicated that the resident was on contact precautions and the signage and PPE supplies should have been available outside of the room. She remembers that they were there but were removed.<br><br>Interview with the Infection Preventionist on January 17, 2025, at 1:54 p.m. confirmed that Resident 34 was on transmission-based precautions, the signs should have been posted, and the PPE should have been available outside of the room, but it was removed by someone.<br><br>A quarterly MDS assessment for Resident 63, dated November 6, 2024, revealed that the resident had moderate cognitive impairment, required assistance from staff with personal care needs, had diagnoses that included diabetes, and had one unstageable pressure ulcer.<br><br>Review of a skin and wound note for Resident 63, dated January 14, 2025, at 2:23 p.m. revealed that the resident was seen for follow up skin and wound care, and that the resident developed a wound to her right lateral (on the side) foot that was found on October 16, 2024. There was no documented evidence that EBP were implemented for Resident 11 until November 27, 2024.<br><br>(continued on next page) |

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| (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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An annual MDS assessment for Resident 70, dated September 2, 2024, indicated that the resident was cognitively impaired, had a feeding tube, and had diagnoses that included Parkinson's disease (a chronic and progressive neurological disorder that affects movement, balance, and coordination).<br><br>Physician's orders for Resident 70, dated August 29, 2024, included an order for the resident to receive Jevity 1.5 (feeding formula) at 55 cubic centimeter's (cm's) per hour every shift. There was no documented evidence that EBP were implemented for Resident 70 until November 27, 2024.<br><br>A quarterly MDS assessment for Resident 80, dated June 30, 2024, indicated that the resident was cognitively impaired and had an indwelling urinary catheter (a flexible tube inserted and held in the bladder to drain urine). A care plan, initiated September 22, 2023, revealed the resident had an indwelling urinary catheter.<br><br>Physician's orders for Resident 80, dated December 14, 2023, included an order for the resident to have an indwelling urinary catheter and to have it changed every 30 days. There was no documented evidence that EBP were implemented until November 27, 2024.<br><br>Interview with the Director of Nursing on January 15, 2025, at 1:29 p.m. confirmed that the facility did not start to implement EBP until November 27, 2024.<br><br>28 Pa. Code 201.14(a) Responsibility of Licensee.<br><br>28 Pa. Code 201.18(e)(1) Management.<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing Services. |