

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Hampton House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1548 Sans Souci Parkway Wilkes Barre, PA 18702	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>41581</p> <p>Based on observation, and staff interviews it was determined the facility failed to provide housekeeping and maintenance services to maintain a clean and safe resident environment.</p> <p>Findings include:</p> <p>An observation on August 20, 2024, at approximately 1:30 PM revealed in Room B14 Resident 25's tube feeding pump and pole were soiled with dried tube feeding solution dried to the pump and pole. In addition there were dried spots of tube feeding solution on the floor.</p> <p>An observation of the A hall nursing unit medication room on August 22, 2024, at approximately 9:05 AM revealed there was dirt and debris on the floor. A strong mildew and sewage smell was noted throughout the room. A flying bug was observed flying around in this medication room.</p> <p>An observation of the A hall nursing unit shower room on August 22, 2024, at approximately 9:15 AM revealed a large amount of sewer flies in the shower room. These flies were noted to be covering the walls of the shower room. They were observed by the tub and in both shower stalls. There were multiple dead flies noted on the floor, in the tub, or splattered on the walls. There were wet clumps of paper on the shower room floor. The shower curtain was noted to have brown stains on the bottom. There were cracked tiles observed on the wall near the floor.</p> <p>An observation on August 23, 2024, at approximately 8:55 AM revealed Room B14, Resident 25's tube feed pump and pole still had dried tube feeding solution on the pump and pole. The dried spots tube feeding solution remained on the floor.</p> <p>Interview with the Director of Nursing and Nursing Home Administrator on August 23, 2024, at approximately 1:30 PM confirmed the facility is to be maintained on a daily basis to ensure a clean and sanitary environment for the residents.</p> <p>Refer F925</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929</p> <p>Based on review of written facility initiated transfer notices and staff interview it was determined the facility failed to provide sufficiently detailed written notices of facility initiated transfers to the hospital to the resident and the residents' representative for seven out of 20 residents reviewed (Resident 32, 87, 91, 46, 66, 31, and 40).</p> <p>Findings include:</p> <p>A review of the clinical record of Resident 32 revealed that the resident was transferred to the hospital on April 8, 2024, and returned to the facility on [DATE].</p> <p>A review of the clinical record of Resident 87 revealed that the resident was transferred to the hospital on May 8, 2024, and returned to the facility on [DATE].</p> <p>A review of the clinical record of Resident 91 revealed that the resident was transferred to the hospital on May 10, 2024, and returned to the facility on [DATE].</p> <p>A review of the clinical record of Resident 46 revealed that the resident was transferred to the hospital on May 30, 2024, and returned to the facility on [DATE].</p> <p>A review of the clinical record of Resident 66 revealed the resident was transferred to the hospital on July 16, 2024, and returned to the facility on [DATE]. The resident was transferred to the hospital again on July 29, 2024 and returned on August 5, 2024.</p> <p>A review of the clinical record of Resident 31 revealed the resident was transferred to the hospital on August 13, 2024, and returned to the facility on [DATE].</p> <p>A review of the clinical record of Resident 40 revealed the resident was transferred to the hospital on June 2, 2024 and returned to the facility on [DATE].</p> <p>A review of the facility's Notice of Transfer on Discharge revealed the written notices lacked the correct address and phone number for assistance with the appeal process, and lacked the correct address, phone number, and email address for the advocacy of persons with disabilities and mental health to seek the assistance of the Disability Rights Pennsylvania.</p> <p>During an interview with the Nursing Home Administrator on August 23, 2024 at approximately 1:30 PM confirmed the information provided to the residents was incorrect.</p> <p>28 Pa. Code 201.29(h) Resident rights</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on clinical record review and staff interviews, it was determined the facility failed to develop person-centered care plans that include individual medication therapy for one resident out of 20 sampled (Resident 12).</p> <p>Findings include:</p> <p>A review of the clinical record revealed Resident 12 was admitted to the facility on [DATE], with diagnoses to include hypertension (high blood pressure).</p> <p>A review of a physician order, initially dated April 30, 2024 revealed the resident was receiving Eliquis Oral Tablet 2.5 MG (anticoagulant medication-commonly known as a blood thinner, chemical substance that prevents or reduces the coagulation of blood, prolonging the clotting time) give twice a day for history of pulmonary embolism (blood clot in the lung).</p> <p>A review of the current resident's plan of care revealed the resident's care plan failed to identify the resident's anticoagulant therapy and interventions to monitor for bleeding.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on August 23, 2024, at approximately 1:30 PM confirmed the facility failed to ensure that comprehensive care plans were developed.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944</p> <p>Based on a review of clinical records, and staff interview, it was determined the facility failed to provide nursing services consistent with professional standards of practice by failing to ensure physician ordered medication, an antibiotic, and additive were timely obtained and administered to treat a urinary tract infection for one resident (Resident 93) out of 20 sampled residents.</p> <p>Findings include:</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care:</p> <p>Assessments</p> <p>Clinical problems</p> <p>Communications with other health care professionals regarding the patient</p> <p>Communication with and education of the patient, family, and the patient's designated support person and other third parties.</p> <p>A review of Resident 93's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included Guillain-Barre Syndrome (a disorder of the immune system where the nerves are attacked by immune cells that causes weakness and tingling in arms and legs), neuromuscular dysfunction of the bladder (a type of bladder dysfunction caused by nerve, brain, or spinal cord damage with symptoms that include loss of bladder control and retaining urine), and urine retention (an inability to completely empty the bladder).</p> <p>A review of urine analysis (UA is a common diagnostic test that evaluates the content, concentration, and appearance of urine and helps detect and manage a wide range of disorders such as urinary tract infections, kidney disease, and diabetes), and culture and sensitivity (urine culture is a method to grow and identify bacteria that may be in the urine. The sensitivity test helps select the best medicine to treat the infection) results that were received by the facility on July 24, 2024, at 11:03 a.m., revealed that Resident 93 had positive urine cultures and confirmed a urinary tract infection.</p> <p>A review of a nurse progress noted completed by Employee 1, a Licensed Practical Nurse (LPN), dated July 25, 2024, at 2:28 p.m., revealed that C & S results were reviewed with the CRNP (Certified Registered Nurse Practitioner) with new orders for Ceftriaxone (an antibiotic in the form of an injection that treats bacterial infections), give 1 gram (gm) intramuscularly (a technique used to deliver a medication deep into the muscles) for 7 days. The Physician, resident, and responsible party (RP) were aware.</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>A review of a physician's order dated July 26, 2024, at 4:12 p.m., revealed an order for an antibiotic, Ceftriaxone SodiumInject 1 gram intramuscularly one time a day for UTI for 7 Days reconstitute (restore to a former condition by adding water) with Lidocaine (numbing medication).</p> <p>A review of Resident 93's medication administration record (MAR) is the report that serves as a legal record of the drugs administered to a resident at a facility by a health care professional) dated July 2024, revealed on July 27, 2024, the resident did not receive the prescribed IM antibiotic Ceftriaxone Sodium.</p> <p>Further review of the clinical record revealed an order administration note completed by Employee 1, dated July 27, 2024, at 7:01 p.m., indicated the Ceftriaxone Sodium Injection was not administered due to the facility waiting for Lidocaine from the pharmacy.</p> <p>During an interview with the Director of Nursing (DON) on August 22, 2024, at 1:45 p.m., it was reported that in the event a physician prescribed treatment was not provided by the facility's primary contracted pharmacy, nursing staff were to contact the contracted emergency pharmacy to prevent a delay in the medication administration.</p> <p>Resident 93's clinical record failed to reveal the resident's physician was timely notified of the missed dose of antibiotic therapy. The facility failed to ensure that Resident 93 received the antibiotic doses as prescribed by the physician to treat the UTI and failed to utilize services of the facility's contracted emergency pharmacy to prevent a delay in treatment.</p> <p>Interview with the DON on August 23, 2024, at 11:00 a.m., confirmed the facility failed to administer physician ordered medication as prescribed, and failed to ensure the MD was notified of a missed dose. Additionally, the DON confirmed that nursing staff failed to implement emergency provisions to contact the contracted emergency pharmacy to prevent a delay in treatment.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on review of select facility policy, clinical records, and staff interview, it was determined the facility failed to implement individualized approaches for incontinence to provide maintenance care to the extent possible for one out of 20 sampled residents (Resident 25).</p> <p>Findings include:</p> <p>A review of facility policy entitled Urinary and Bowel Incontinence Evaluation and Management last reviewed April 17, 2024, indicated if a resident is not a candidate for a schedule, they will be placed on Incontinence Care and Comfort (checked and changed every two to three hours).</p> <p>A review of Resident 25's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included dementia (a decline in cognitive abilities that can affect a person's ability to perform everyday activities) and muscle wasting.</p> <p>A review of the resident's bladder and bowel evaluation dated July 21, 2024, revealed the resident was always incontinent of bowel and bladder, has poor a potential for a toileting schedule, and was placed on an incontinence care and comfort plan.</p> <p>A review of the resident's current plan of care failed to identify the resident's urinary incontinence and interventions to provide care and services.</p> <p>A review of the resident's clinical record revealed the facility failed to document the resident's incontinence care and comfort care plan was being implemented and completed each shift.</p> <p>Interview with the Director of Nursing on August 23, 2024, at approximately 1:30 PM confirmed the facility failed to provide maintenance care to Resident 25.</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929</p> <p>Based on a review of clinical records and select facility policies and staff interview, it was determined the facility failed to consistently and accurately monitor resident weights to</p> <p>timely identify changes in nutritional parameters for two of 20 sampled residents (Residents 40 and 91).</p> <p>Findings include:</p> <p>The facility policy Weight Policy dated as revised June 2024, indicated that any resident with weight changes of five or more pounds will be re-weighed within 72 hours post the original weight by the assigned CNA/designee and nurse. The Dietician will review the medical record of residents with significant weight changes (greater than or equal to 5% in 1 month, greater than or equal to 7.5% in 3 months, and greater than or equal to 10% in 6 months). Interventions will be recommended, as needed. Interventions that are initiated in response to a weight change will be reflected in the care plan. Residents with significant weight loss/gain will be further reviewed by the IDCPT (interdisciplinary care plan team) meetings.</p> <p>A review of Resident 's 40's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include diabetes (commonly referred to as diabetes, is a group of metabolic diseases in which there are high blood sugar levels over a prolonged period) and heart disease.</p> <p>A Dietary Progress Note created by the Registered Dietitian (RD) dated July 18, 2024, revealed Resident 40 weighed 167 lbs. on July 4, 2024, and 133 lbs. on July 18, 2024, which was a 19.9% weight loss in 30 days, losing 34 lbs. in 2 weeks. Further review indicated the RD questioned the accuracy of the weight however, a reweigh confirmed the significant weight loss. There were no new interventions implemented at the time of the weight loss. The RD did not implement a new intervention until August 6, 2024, at which time she recommended the addition of a magic cup (nutritional supplement to enhance weight gain) three times a day.</p> <p>Review of Resident 40's current nutritional care plan in place at the time of survey ending August 23, 2024, revealed no revisions were made since April 4, 2024.</p> <p>Interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on August 23, 2024, at approximately 9:20 AM, confirmed the facility failed to follow the facility's weight policy.</p> <p>A review of Resident 91's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included anoxic brain damage (is damage to the brain due to a lack of oxygen supply), alcohol abuse, alcohol induced pancreatitis (inflammation of the pancreases that is caused by chronic, excessive alcohol consumption), and dysphagia (difficulty swallowing).</p> <p>(continued on next page)</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>Additionally, Resident 91 was NPO (nothing by mouth) and required a feeding tube, a medical device used to provide nutrition to which cannot be obtained by mouth, are unable to swallow safely, or need nutritional supplementation. The state of being fed by a feeding tube is also referred to as an enteral feeding or tube feeding. The tube feeding would assist the resident to meet his estimated calorie, protein, hydration, and other essential nutrients related to the inability to safely consume foods and fluids orally.</p> <p>A review of Resident 91's readmission comprehensive nutritional assessment completed by the Registered Dietitian (RD) dated May 21, 2024, at 8:00 AM, revealed the resident's current weight upon readmission was 110 pounds and the weight prior to hospitalization was 150 pounds and noted the resident had frequent weight changes due to jerky movements in the mechanical lift causing inaccurate weights. Continue with weekly weights as able and continue with current tube feeding regimen and update as needed (PRN).</p> <p>A review of Resident 91's weight record indicated the following weights:</p> <p>June 11, 2024, at 9:38 AM, via mechanical lift - 143.2 pounds</p> <p>June 14, 2024, at 2:35 AM, via mechanical lift - 127 pounds</p> <p>June 18, 2024, at 2:08 AM, via mechanical lift - 127.3 pounds</p> <p>There was no documented evidence the facility obtained a timely re-weight (72-hours) between June 14, 2024, and June 18, 2024, after a significant weight loss of 16.2 pounds in less than a week.</p> <p>A review of Resident 91's clinical record revealed a weight change note completed by the RD on June 18, 2024, at 9:17 PM, which identified the resident had a significant weight change and indicated the weight changes were secondary to jerky movements during the weight being taken. It was noted the resident continued enteral feed order, no intolerances per nursing, running as ordered. Tube feeding providing 2400 calories, 111 grams protein and was adequate to meet the resident's higher end of the estimated nutrient needs and continue to monitor weight status, no new recommendations at this time.</p> <p>Additionally, a weight change note completed by the RD on July 24, 2024, at 8:25 PM, indicated the resident continued with fluctuating weight status between 125 and 140 pounds and that weight appears stable. Tube feeding continues at goal and meeting upper end of estimated nutrient needs. Will continue to monitor.</p> <p>Further review of the resident's weight record revealed the following recorded weekly weights:</p> <p>July 25, 2024, at 3:46 PM via mechanical lift - 132 pounds</p> <p>July 30, 2024, at 2:03 PM via mechanical lift - 127 pounds (loss of 5-pounds in five days)</p> <p>August 8, 2024, at 1:38 PM via mechanical lift - 136.5 pounds (gain of 9.5-pounds in eight days)</p> <p>August 13, 2023, at 2:09 p.m., via mechanical lift- 132-pounds (loss of 4.5 pounds in five days)</p> <p>(continued on next page)</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>The facility failed to timely obtain re-weights and attempt to obtain accurate methods of weighing a dependent resident to perform an accurate assessment of nutritional requirements.</p> <p>An interview with the Nursing Home Administrator on August 23, 2024, at 10:25 AM confirmed that re-weights were not obtained in a timely manner and that alternative methods of weighing the dependent resident was not explored to ensure accurate estimations of nutritional requirements.</p> <p>28 Pa. Code S201.18(b)(1)(3) Management</p> <p>28 Pa Code 211.5(f)(ix) Medical records</p> <p>28 Pa. Code S211.10(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5)Nursing Services.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929</p> <p>Based on a review of clinical records and staff interview, it was determined the facility failed to develop and implement an effective individualized person-centered plan to address a resident's dementia-related behavioral symptoms for one out of 20 residents reviewed (Resident 86).</p> <p>Findings include:</p> <p>A review of Resident 86's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include dementia (a progressive brain disorder that affects memory, thinking, and behavior)</p> <p>A review of Resident 29's Quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 13, 2024, revealed the resident was severely cognitively impaired.</p> <p>A review of progress notes in the resident's clinical record dated from February 01, 2024 to August 24, 2024, revealed the resident exhibited behaviors of intrusive wandering, striking out, screaming, and agitation.</p> <p>The resident's current care plan in effect at the time of the survey ending August 23, 2024, did not address her diagnosis of Dementia.</p> <p>The facility failed to develop and implement an individualized person-centered plan to address, modify and manage this resident's dementia-related behaviors. The resident's care plan for dementia failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage, modify or decrease the resident's dementia-related behavioral symptoms.</p> <p>The facility failed to demonstrate the provision of necessary care and services, including individualized interdisciplinary non-pharmacological approaches to care, purposeful and meaningful activities, that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being. There was no evidence the facility provided the resident with specialized services and supports, such specialized activities, nutrition, and environmental modifications, based on the individual's abilities and dementia related behaviors</p> <p>Interview with Nursing Home Administrator on August 23, 2024, at approximately 10:00 a.m., confirmed the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to address the resident's dementia-related behaviors.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing services</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a review of clinical records and staff interview, it was determined the attending physician failed to act upon pharmacist identified irregularities in the medication regimen of four of 20 residents sampled (Resident 12, 47, 86, and 46).</p> <p>Findings include:</p> <p>A review of the clinical record revealed Resident 12 was admitted to the facility on [DATE], and had diagnoses that included bipolar disorder (serious mental illness characterized by extreme mood swings, a mood disorder that causes radical emotional changes and mood swings, from manic, restless highs to depressive, listless lows. Most bipolar individuals experience alternating episodes of mania and depression).</p> <p>A review of an April 2024 Note to Attending Physician/Prescriber revealed the consultant pharmacist indicted the resident was recently admitted with an order for Quetiapine Fumarate (antipsychotic medication) oral tablet 25mg three times a day related to bipolar disorder and the medication needed to be evaluated for the effectiveness and if a GDR (gradual dose reduction) could be attempted.</p> <p>Further review revealed the resident's attending physician failed to write an appropriate response to the pharmacy recommendation. Instead, the facility's consultant psychiatric CRNP (certified registered nurse practitioner) had responded to the pharmacy recommendation and signed off as she (CRNP) reviewed it.</p> <p>A review of the clinical record revealed Resident 47 was admitted to the facility on [DATE], and had diagnoses that included depressive disorder and mood disorder.</p> <p>A review of a January 2024 Note to Attending Physician/Prescriber revealed the consultant pharmacist indicted the resident has an order for Depakote sprinkles (anti-seizure medication that is effective to treat bipolar disorder) 250mg by mouth one time a day for mood. The medication was due for an assessment in accordance with CMS (Centers for Medicare Medicaid Services) guidelines for psychopharmacological medications and if no dose reduction is indicated, please include a brief resident specific rationale.</p> <p>A second recommendation was made by the pharmacist during the month of January 2024 indicating the resident had an order for Lexapro (antidepressant) 15 mg for depressive disorder. This medication was due for an assessment in accordance with CMS guidelines for psychopharmacological medications and if no dose reduction was indicated please include a brief resident specific rationale.</p> <p>Further review revealed the resident's attending physician failed to write an appropriate response to the pharmacy recommendation. Instead, the facility's consultant psychiatric CRNP (certified registered nurse practitioner) had responded to the pharmacy recommendation and signed off as she reviewed it.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Hampton House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1548 Sans Souci Parkway Wilkes Barre, PA 18702	
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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a March 2024 Note to Attending Physician/Prescriber revealed the consultant pharmacist indicted the resident had an order for Seroquel 25mg every day for reoccurring depressive disorder. The pharmacist noted the resident's behaviors appear to occur mostly around bedtime, but the medication was being administered at 9:00 AM. The medication was due for an assessment in accordance with CMS guidelines for psychopharmacological medications and if no dose reduction is indicated, please include a brief patient specific rationale.</p> <p>Further review revealed the resident's attending physician failed to write an appropriate response to the pharmacy recommendation. Instead, the facility's consultant psychiatric CRNP (certified registered nurse practitioner) had responded to the pharmacy recommendation and signed off as she reviewed it.</p> <p>A review of the clinical record revealed Resident 86 was admitted to the facility on [DATE], and had diagnoses that included dementia.</p> <p>A review of a May 2024 Note to Attending Physician/Prescriber revealed the consultant pharmacist indicted the resident had an order for Seroquel (antipsychotic) 50 mg twice a day for unspecified dementia. The medication was due for an assessment in accordance with CMS guidelines for psychopharmacological medications and if no dose reduction is indicated, please include a brief patient specific rationale.</p> <p>Further review revealed the resident's attending physician failed to write an appropriate response to the pharmacy recommendation. Instead, the facility's consultant psychiatric CRNP (certified registered nurse practitioner) had responded to the pharmacy recommendation and signed off as she reviewed it.</p> <p>A review of Resident 64's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior and is a gradually progressive condition).</p> <p>A review of a January 2024 Note to Attending Physician/Prescriber revealed the consultant pharmacist indicted the resident had an order for Depakote 250 mg three times per day for a mood disorder. The medication was due for an assessment in accordance with CMS guidelines for psychopharmacological medications and if no dose reduction is indicated, please include a brief patient specific rationale.</p> <p>Further review revealed the resident's attending physician failed to write an appropriate response to the pharmacy recommendation. Instead, the facility's consultant psychiatric CRNP (certified registered nurse practitioner) had responded to the pharmacy recommendation and signed off as she reviewed it.</p> <p>A review of a Resident 64's May 2024 Note to Attending Physician/Prescriber revealed the consultant pharmacist indicted the resident had an order for Trazadone 25 mg daily at bedtime for anxiety disorder. The medication was due for an assessment in accordance with CMS guidelines for psychopharmacological medications and if no dose reduction is indicated, please include a brief patient specific rationale.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review revealed the resident's attending physician failed to write an appropriate response to the pharmacy recommendation. Instead, the facility's consultant psychiatric CRNP (certified registered nurse practitioner) had responded to the pharmacy recommendation and signed off as she reviewed it.</p> <p>Further review revealed the resident's attending physician failed to document an individualized response to the pharmacy recommendations. Instead, the facility's consultant psychiatric CRNP had responded to the pharmacy recommendation and signed off as she reviewed the recommendations.</p> <p>In an interview with the Director of Nursing on August 23, 2024, at approximately 1:30 PM confirmed that consultant psychiatric CRNP was responding to the pharmacy recommendations and not the resident's attending physician as noted in the regulation.</p> <p>28 Pa. Code 211.9 (k) Pharmacy services.</p> <p>28 Pa. Code 211.12 (c) Nursing services.</p> <p>28 Pa. Code 211.2 (d)(3) Medical Director</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43944</p> <p>Based on review of facility policy, observation and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department.</p> <p>Findings include:</p> <p>Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food).</p> <p>A review of a facility policy entitled Cleaning Dishes: Manual Dishwashing last reviewed by the facility on April 17, 2024, indicated that sink 1 - wash procedure should include cleaning the sink and measure the appropriate amount of water into the sink to the water line and determine the amount of detergent to be used, following the manufactures directions for use. Sink 2 - rinse procedure was to include preparing the sink with hot water (120 degrees - 140 degrees Fahrenheit) and rinse the dishes thoroughly before placing in the sanitizing sink. Sink 3 - sanitize procedure was to include measuring the appropriate amount of sanitizing chemical into the appropriate amount of water (following manufacture's guidelines) and testing the sanitizing solution using the manufacture's suggested test strips to assure appropriate level before placing the dishes into the sanitizing sink.</p> <p>Further review of a posted procedure guide entitled Pot and Pan Cleaning and Sanitizing Procedures revealed the level of sanitation testing solutions should be between 200 - 400 parts per million (PPM is a unit of measurement used to express concentrations of a substance in a solution or mixture).</p> <p>The initial tour of the kitchen conducted with the facility's Food Service Manager on August 20, 2024, at 8:58 a.m., revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness:</p> <p>Observed inside the 3-compartment sink (is a piece of manual equipment used for cleaning and sanitizing dishes, utensils, and equipment used in the kitchen) labeled sanitize observed that cooking/baking equipment, such as whisks, pans, pots, etc., were soaking inside of the compartment in a pale pink solution. A test strip test was conducted, and the test strip turned an orange color and indicated zero (0) parts per million (ppm) of sanitation solution.</p> <p>The Food Service Manager confirmed the observation and the test strip results and indicated the sanitize compartment should have read between 200 - 400 PPM and was not sure why the sanitize solution was so weak.</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 - Many</p>	<p>Observations of the ceiling tiles of the dietary department revealed several tiles throughout the department that were splattered with a brownish colored substance.</p> <p>Outside of the dish room area and near the cook's preparation area, mobile garbage reciprocal with no lid was overflowing with bagged trash.</p> <p>Observed that the wall exiting the kitchen and leading into the dining room had an accumulation of dust and debris adhered to the wall surfaces.</p> <p>Observations of the exhaust hood over the stove/cook top revealed two dried, hard, discolored white rags that stuck inside two corners of the hood.</p> <p>Observed a white plastic container with a label bulk hard-boiled eggs with dry white rice stored inside. Also, one of the four lid corners was cracked and exposed the contents making it available to contamination.</p> <p>Further observation of the dietary department revealed the hosing attached to the water filter and coffee maker were heavily corroded with dust and debris.</p> <p>Interview with the Food Service Manager on August 20, 2024, at 9:30 a.m., confirmed the above observations and indicated the kitchen areas should be maintained in a sanitary manner to prevent opportunities for contamination and foodborne illness.</p> <p>28 Pa. Code 201.18 (e)(1) (2.1) Management</p> <p>28 Pa. Code 211.6 (f) Dietary Services</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>41581</p> <p>Based on observations, a review of facility pest service records and staff interview, it was determined the facility failed to maintain an effective pest control program throughout multiple areas of the facility.</p> <p>Findings include:</p> <p>An observation of the A hall nursing unit medication room on August 22, 2024, at approximately 9:05 AM revealed a strong mildew and sewage smell throughout the room. A flying bug was seen in the med room.</p> <p>An observation of the A hall nursing unit shower room on August 22, 2024, at approximately 9:15 AM revealed a large amount of sewer flies in the shower room. These flies were noted to be covering the walls of the shower room. They were noted by the tub and in both shower stalls. There was multiple dead flies noted on the floor, in the tub, or flattened on the wall.</p> <p>An interview with Employee 1 LPN (license practical nurse) on August 22, 2024, at approximately 9:25 AM revealed the employee stated the bugs have been an ongoing issue in the facility. She stated that they have been a problem for at least four months and have become worse over the summer. The employee stated she has observed the bugs in the shower room and in the medication room.</p> <p>A review of the contracted pest control company's service reports for general pest control maintenance for the facility revealed the pest control company did not begin to treat for the flies until July 9, 2024, despite staff indicating the fly infestation has been going on for at least four months.</p> <p>A review of a pest control report dated July 9, 2024, revealed the company treated the A wing shower room for drain flies. The pest company failed to provide recommendations to the facility about providing treatments to the drains to ensure the flies would be controlled between visits.</p> <p>A review of a pest control report dated July 23, 2024, revealed the flies remained a problem in the A wing shower room and a treatment was provided again. The pest control once again failed to provide any recommendations to the facility on how to continue to treat the drains to ensure the files would be controlled between visits.</p> <p>A review of a facility work order dated July 30, 2024, revealed the treatment to the drains did not work and it was reported there were bugs that were all over the walls of the A wing shower room. At that time the facility sprayed to kill the flies, but no treatments were provided to the drains to try to eradicate the flies.</p> <p>A review of a pest control report dated August 6, 2024, revealed once again the pest company noted the presence of flies in the shower room and now in the medication room of the A wing nursing unit. The pest company applied the same treatment as the last two visits that failed to work. The pest control company suggested at that time that better sanitation and treatment should be completed but failed to identify the treatment should.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Nursing Home Administrator (NHA) on August 23, 2024, at 1:30 PM, confirmed that the facility failed to complete the necessary measures to maintain an effective pest control program.</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</p>