

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Forest Park Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Walnut Bottom Road Carlisle, PA 17013	

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 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>46253</p> <p>Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to promote care for residents in a manner and environment that enhances each resident's dignity for two of 23 Residents reviewed (Residents 9 and 31).</p> <p>Findings Include:</p> <p>Review of facility policy, titled Dignity, with a last revised date of February 2021, revealed, in part: 11. Staff promote, maintain, and protect resident privacy, including bodily privacy ; and 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a) helping the resident to keep urinary bags covered.</p> <p>Review of Resident 9's clinical record revealed diagnoses that included cerebral infarction (a stroke - damage to the brain from interruption of its blood supply), abnormal posture, and stiffness of left hand.</p> <p>Observation of Resident 9 on April 16, 2024, at 9:39 AM, revealed that she was sitting in her wheelchair in the unit common area at a table. Her shirt was slightly raised up, her pants were slightly down on her belly, her belly was partially exposed, and a portion of her incontinent brief was visible over the waist of her pants. A staff member dressed in scrubs was witnessed speaking to and providing Resident 9 a snack, and then immediately exiting the unit.</p> <p>Observation of Resident 9 was shared with Employee 4 on April 16, 2024, at 9:42 AM. Employee 4 went to the Resident and confirmed that she should not have been left that way, and immediately asked a nurse aide to provide care for Resident 9.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 17, 2024, at 2:01 PM, the DON confirmed that Resident 9 should not have been left like that by a staff member.</p> <p>Review of Resident 31's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure).</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident 31's clinical record revealed that she had a urinary catheter.</p> <p>Observation of Resident 31 on April 16, 2024, at 9:30 AM, revealed that she was lying in bed and three incontinent briefs were present on her night stand, visible from the hallway.</p> <p>Observation of Resident 31 on April 17, 2024, at 8:26 AM, revealed that she was lying in bed, her urinary catheter drainage bag was lying on the floor beside her bed and approximately half full with yellow urine, and her dignity cover for her catheter drainage bag was located on her wheelchair. The aforementioned was all visible from the hallway.</p> <p>The observation of Resident 31 was shared with Employee 2 on April 17, 2024, at 8:30 AM. Employee 2 confirmed that the urinary catheter drainage bag was visible from the hallway and should have been in a dignity cover. Employee 2 was witnessed to place the catheter drainage bag into the dignity cover.</p> <p>During an interview with the NHA and DON on April 17, 2024, at 1:52 PM, the aforementioned observations were shared. The DON confirmed that Resident 31's catheter drainage bag should have been in a dignity cover and that briefs should not be left out in open view.</p> <p>A follow-up observation of Resident 31 on April 18, 2024, at 11:20 AM, revealed that she was in bed, her urinary catheter drainage bag was lying beside her feet on her bed with yellow urine noted in the bag, and the dignity cover for her catheter drainage bag was located on her wheelchair. The aforementioned was visible from the hallway.</p> <p>During a final interview with the NHA and DON on April 18, 2024, at 11:20 AM, the aforementioned follow-up observation was shared. The DON again confirmed that Resident 31's urinary catheter drainage bag should have been in her dignity cover.</p> <p>28 Pa. Code 201.18(b)(2) Management</p> <p>28 Pa. Code 201.29(a) Resident Rights</p> <p>28 Pa. Code 211.12(d)(1)(2) Nursing Services</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>40010</p> <p>Based on review of select facility documentation and staff interview, it was determined that the facility failed to provide the required notice to the resident or the resident's representative following the end of their Medicare coverage for one of two residents reviewed (Resident 60).</p> <p>Findings include:</p> <p>A Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form completed by the facility on April 18, 2024, revealed that Medicare coverage for Resident 60 began on November 1, 2023, and that her last covered day was November 16, 2023. The form indicated that the facility-initiated discontinuation from Medicare Part A coverage and that the Resident's benefit days were not exhausted. Further review of the form revealed that an Advanced Beneficiary Notice of Non-coverage (ABN - a notice given to Medicare beneficiaries to convey that Medicare is not likely to provide coverage for a skilled service) was not provided to the Resident or her Representative at the time that Medicare Part A was discontinued.</p> <p>During an interview with the Nursing Home Administrator on April 18, 2024, at 1:49 PM, she revealed the expectation that the appropriate notices should have been provided to Residents 60.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>37013</p> <p>Based on observations and resident and staff interviews, it was determined that the facility failed to ensure the resident's right to a clean, comfortable, and homelike environment for one of three shower rooms observed (Laurel Lane) and two of four nursing units observed (Evergreen and Chapelwood).</p> <p>Findings Include:</p> <p>Observations of Resident 9's wheelchair on the Chapelwood unit on April 15, 2024, at 9:29 AM; April 17, 2024, at 8:12 AM; and April 17, 2024, at 10:02 AM, revealed that the base of her wheelchair had a moderate amount of dry dusty appearing debris, and the seat cushion had a small amount of dried food debris.</p> <p>Observation of Resident 15's room on the Chapelwood unit on April 15, 2024, at 9:03 AM, revealed the following: one of the closet doors was off track, leaning into closet and causing the other closet door to be pushed outward at the floor; there were missing slats from the window blinds lying on the floor; the Resident's wheelchair had food debris noted on the seat surface; the clear plastic chair rail along the wall, near the head of the bed, had a brown sticky appearing substance noted; there were brown smears on wall by the side of the; the baseboard molding was peeling away from the wall; there were stains noted on the upper portion of wall above bed, where the lighting unit was located; and there was a strong odor of urine in the bathroom with a brown splatter noted on the left side of the toilet, the floor around the base of toilet was dark brown in color, and the tank cover toilet tank cover was chipped.</p> <p>Observation of Resident 15's room on April 16, 2024, at 9:55 AM, and on April 17, 2024, at 8:09 AM and 10:01 AM, revealed that all the aforementioned observations were still present. In addition, there was a large amount of a brown substance all over the toilet seat.</p> <p>Observation of Resident 15's room on April 17, 2024, at 12:11 PM, revealed that the toilet seat had been cleaned, but all the other aforementioned observations remained.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 17, 2024, at 1:45 PM, all the aforementioned environmental concerns for Resident 9 and 15 were shared for further follow-up.</p> <p>A follow-up observation of Resident 9's wheelchair on April 18, 2024, at 9:20 AM, revealed that all the same aforementioned concerns remained.</p> <p>A follow-up observation of Resident 15's room on April 18, 2024, at 9:17 AM, revealed that the closet doors had been repaired, the blind slats had been removed from the floor, and the toilet had been cleaned. All other aforementioned concerns still remained.</p> <p>During a final interview with the NHA and DON on April 18, 2024, at 11:32 AM, the NHA confirmed that she would expect the residents to have a clean homelike environment.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on Chapelwood unit revealed the following:</p> <ul style="list-style-type: none"> - On April 15, 2024, at 8:03 AM; April 16, 2024, at 8:03 AM; and on April 17, 2024, at 10:28 AM: a discolored, golf-ball sized open hole in the ceiling was present above the couch in the common area. Smears of a brown substance were present on the arm and seat of a blue couch in the common area. - On April 15, 2024, at 8:15 AM; on April 16, 2024, at 8:08 AM; and on April 17, 2024, at 10:32 AM: the closet door in Resident 32's room was disconnected from the hinges, and was leaning/propped against the closet/other door. The baseboard inside of Resident 32's room to the left of the entrance was falling off of the wall and was laying on the floor. Bits of plaster were present on the floor. - On April 15, 2024, at 9:54 AM, and on April 17, 2024, at 10:33 AM: a coffee-can sized round, sunken area was present in the hallway between Resident 51 and 66's rooms. <p>During an interview with the NHA on April 17, 2024, at 2:36 PM, she confirmed that there were no pending work orders for the Chapelwood unit.</p> <p>During an interview with the DON on April 18, 2024, at 11:56 AM, she revealed the expectation that the aforementioned concerns should have been corrected.</p> <p>Per email correspondence received from the NHA on April 18, 2024, at 2:58 PM, the blue couch on Chapelwood unit had been cleaned.</p> <p>An interview with Resident 39 on April 16, 2024, at 10:16 AM, revealed that on several occasions upon going into the shower room for a shower, there was feces on the floor.</p> <p>Observation of the shower room on Laurel Lane on April 16, 2024, at 10:25 AM, revealed three large brown chunks of a substance on the shower floor and a brown substance smeared on the shower floor.</p> <p>Observation of the shower room on Laurel Lane on April 17, 2024, at 9:31 AM, revealed a brown substance smeared on the shower room floor.</p> <p>An interview with the DON on April 18, 2024, at 11:15 AM, revealed that she would expect the shower room be kept clean for the residents use.</p> <p>Observation of Resident 207's room on the Evergreen Unit on April 15, 2024, at 10:03 AM, revealed a brown substance splattered on the wall near Resident 207's nightstand.</p> <p>Additional observations on April 16, 2024, at 9:07 AM, and April 17, 2024, at 10:22 AM, revealed the same brown substance splattered on the wall.</p> <p>On April 17, 2024, at 1:49 PM, the NHA and DON were made aware of the observations of Resident 207's room.</p> <p>Observation of Resident 207's room on April 18, 2024, at 11:10 AM, revealed the same brown substance remained splattered on the wall.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On April 18, 2024, at 12:13 PM, observation of Resident 207's room was made with the NHA present. At that time, the NHA acknowledged the brown splatters on Resident 207's wall.</p> <p>No additional information was provided.</p> <p>Observation of Resident 407's room on the Evergreen Unit on April 15, 2024, at 9:34 AM, revealed four blind slats lying on the floor below the window.</p> <p>An additional observation on April 16, 2024, at 9:26 AM, revealed the blind slats remained on the floor below the window.</p> <p>On April 17, 2024, at 2:40 PM, the NHA and DON were made aware of the observations of Resident 407's room.</p> <p>No additional information was provided.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>37013</p> <p>Based on observation, facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to investigate an injury of unknown origin to rule out abuse, neglect, or mistreatment for one of 29 residents reviewed (Resident 72).</p> <p>Findings Include:</p> <p>Review of facility policy, titled Forest Park Abuse Policy, with a review/revise date of April 24, 2018, revealed Injury of unknown source is defined as an injury that meets both of the following conditions: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of: (a) the extent of the injury; or (b) the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); or (c) the number of injuries observed at one particular point in time; or (d) the incidence of injuries over time.</p> <p>Review of Resident 72's clinical record revealed diagnoses that included Type 2 Diabetes Mellitus and unstageable left heel pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin).</p> <p>Observation of Resident 72 on April 15, 2024, at 8:45 AM, revealed Resident 72 with a bruise on the underside of his left upper arm, between his elbow and armpit.</p> <p>During an interview Resident 72 at that time, he pointed out the bruise, but was unable to state how the bruise occurred.</p> <p>Review of Resident 72's clinical record revealed no mention or assessment of Resident 72's bruise.</p> <p>On April 17, 2024, at 2:46 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were made aware of the observation of Resident 72's bruise. They stated they would look into it.</p> <p>On April 18, 2024, at 10:06 AM, the NHA provided an incident report regarding Resident 72's bruise.</p> <p>Review of Resident 72's incident report revealed that it was dated April 17, 2024. Further review of the incident report revealed that a bruise was found on Resident 72's left upper arm, bluish/purple in color, and measuring 10 cm x 6 cm. Resident 72 stated he is unaware of how the bruise occurred. The incident report further stated that Resident 72 was hospitalized earlier that week. Facility protocol was initiated and staff interviews would be conducted.</p> <p>Review of Resident 72's clinical record revealed that he was transferred to the hospital emergency department on April 14, 2024, and returned to the facility later that same day.</p> <p>During an interview with the NHA and DON on April 18, 2024, at 12:05 PM, the NHA acknowledged that the incident report wasn't completed until the surveyor brought the bruise to their attention.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a follow-up interview with the NHA and DON on April 18, 2024, at 2:21 PM, the DON stated that a skin assessment was not completed on Resident 72 when he returned from the emergency department. The DON further stated that the bruise should have been investigated previously, as it is an injury of unknown origin.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual 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** 33879</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to provide notice of transfer to the resident and/or resident representative, as well as a notice to the Office of the State Long-Term Care Ombudsman, after a transfer out of the facility for seven of 10 residents reviewed for hospitalization (Residents 4, 32, 35, 63, 71, 72, and 89).</p> <p>Findings include:</p> <p>Review of Resident 4's clinical record on April 16, 2024, at approximately 10:30 AM, revealed diagnoses that included hypothyroidism (condition of the thyroid gland that results in decreased production of thyroid hormones) and vascular dementia (progressive, irreversible degenerative disease of the brain that results in decreased reality awareness and decrease in capacity to perform activities of daily living).</p> <p>Review of Resident 4's clinical record revealed that on October 1, 2023, Resident 4 was transferred to a hospital emergency room for concerns of chest pain. The Resident subsequently returned from the hospital to the facility on [DATE].</p> <p>During a staff interview on April 17, 2024, at approximately 1:30 PM, a request was made to the Nursing Home Administrator (NHA) and Director of Nursing (DON) for documentation that Resident 4 or Resident 4's Responsible Party was provided with a transfer notice, along with documentation that the State Ombudsman Office was notified of Resident 4's transfer.</p> <p>During a staff interview on April 18, 2024, at approximately 11:30 AM, the NHA and DON revealed that the facility did not provide transfer notices to the Resident nor notification of transfer to the State Ombudsman Office for Resident 4's October 1, 2023, hospital transfer. During the interview, the NHA revealed that the facility was aware that the required notifications were not conducted at the time of Resident 4's hospital transfer.</p> <p>Review of Resident 32's clinical record revealed diagnoses that included malignant neoplasm of colon (colon cancer) and chronic obstructive pulmonary disease (COPD - chronic inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>Further review of Resident 32's clinical record revealed he was transferred out to the hospital due to a change in condition on January 2, 15, and 28, 2024, and was subsequently admitted each time.</p> <p>Email correspondence received from the DON on April 17, 2024, at 10:12 AM, revealed she was unable to locate any notice of transfers that would have been sent for Resident 32's aforementioned hospital transfers. She also revealed that she was unable to locate evidence that the State Ombudsman was notified of Resident 32's January 2024 hospital transfers.</p> <p>Review of Resident 35's clinical record revealed diagnoses that included Schizoaffective Disorder (a mental health condition including schizophrenia and mood disorder symptoms) and anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident 35's clinical record revealed that he was transferred and admitted to the hospital on February 2, 2024.</p> <p>On April 17, 2024, at 12:08 PM, the DON stated that she was unable to locate the notice of transfer provided to the Resident and/or the Resident Representative at the time of the hospital transfer, and she was also unable to find evidence that the State Ombudsman Office was notified of Resident 35's hospital transfer on February 2, 2024.</p> <p>Review of Resident 63's clinical record on April 17, 2024, at 8:52 AM, revealed diagnoses that included fracture of unspecified part of neck of left femur (type of hip fracture of the thigh bone) and acute posthemorrhagic anemia (condition that develops when you lose a large amount of blood quickly).</p> <p>Further review of Resident 63's clinical record revealed that on January 23, 2024, Resident 63 was transferred out of the facility and was subsequently admitted to the hospital.</p> <p>During a staff interview on April 17, 2024, at 2:41 PM, with the NHA and DON, the surveyor requested a copy of the transfer notice and Ombudsman notification for the aforementioned hospital transfer.</p> <p>During an additional staff interview on April 18, 2024, at 12:02 PM with the NHA and DON, it was revealed the facility was unable to provide additional information. The DON, in the presence of the NHA, stated it had been identified that transfer notices were not being provided to residents or their representatives at the time of transfer, and that staff education had been provided. The DON also stated the facility could not provide documentation the Ombudsman had been notified. The NHA and DON stated that it was the expectation of the facility that transfer notices be given to the Resident and Resident Representative, and that the Ombudsman notifications be sent.</p> <p>Review of Resident 71's clinical record on April 15, 2024, at approximately 9:00 AM, revealed diagnoses that included dementia and atrial fibrillation (irregular heart beat).</p> <p>Review of Resident 71's clinical record revealed that on January 5, 2024, Resident 71 was transferred to the hospital emergency room after chest x-rays revealed possible pneumonia. Resident 71 returned to the facility from the hospital on January 9, 2024.</p> <p>During a staff interview on April 17, 2024, at approximately 1:30 PM, a request was made to the NHA and DON for documentation that Resident 71 or Resident 71's Responsible Party was provided with a transfer notice, along with documentation that the State Ombudsman Office was notified of Resident 71's transfer.</p> <p>During a staff interview on April 18, 2024, at approximately 11:30 AM, NHA and DON revealed that the facility did not provide transfer notices to the Resident, nor notification of transfer to the State Ombudsman Office for Resident 71's January 5, 2024 hospital transfer. During the interview, the NHA revealed that the facility was aware that required notifications were not conducted at the time of Resident 71's hospital transfer.</p> <p>Review of Resident 72's clinical record revealed diagnoses that included Type 2 Diabetes Mellitus and unstageable left heel pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin).</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident 72's clinical record revealed that he was transferred and admitted to the hospital on December 5, 2023.</p> <p>On April 17, 2024, at 1:45 PM, the DON stated that she was unable to locate the notice of transfer provided to the Resident and/or the Resident Representative at the time of the hospital transfer, and she was also unable to find evidence that the State Ombudsman Office was notified of Resident 72's hospital transfer on December 5, 2023.</p> <p>Review of Resident 89's clinical record on April 18, 2024, at 9:15 AM, revealed diagnoses that included urinary tract infection (UTI - an infection caused by bacteria in any part of the urinary system) and acute and chronic respiratory failure with hypoxia (occurs when there is not enough oxygen in the blood).</p> <p>Further review of Resident 89's clinical record revealed that on December 12, 2023, January 9, 2024, and March 8, 2024, Resident 89 was transferred out of the facility and was subsequently admitted to the hospital.</p> <p>During a staff interview on April 18, 2024, at 12:02 PM, with the NHA and DON, the surveyor requested a copy of the transfer notice and Ombudsman notification for the aforementioned hospital transfers. It was revealed that the facility was unable to provide any additional information. The DON, in the presence of the NHA, stated it had been identified that transfer notices were not being provided to residents or their representatives, and that staff education had been provided. The DON also stated the facility could not provide documentation the Ombudsman had been notified. The NHA and DON stated that it was the expectation of the facility that transfer notices be given to the Resident and Resident Representative, and that Ombudsman notifications be sent.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Forest Park Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Walnut Bottom Road Carlisle, PA 17013	

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879</p> <p>Based on clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to provide residents with a copy of the facility's bed-hold policy as a result of a transfer out of the facility for seven of 10 residents reviewed for hospitalization (Residents 4, 32, 35, 63, 71, 72, and 89).</p> <p>Findings include:</p> <p>Review of facility policy, titled Bed-Holds and Returns, last revised March 2022, read, in part, 1. All residents/representatives are provided written information regarding the facility bed-hold policies, which address holding or reserving a resident' bed during period of absence (hospitalization or therapeutic leave). b. at the time of transfer (or, if the transfer was an emergency, within 24 hours).</p> <p>Review of Resident 4's clinical record on April 16, 2024, at approximately 10:30 AM, revealed diagnoses that included hypothyroidism (condition of the thyroid gland that results in decreased production of thyroid hormones) and vascular dementia (progressive, irreversible degenerative disease of the brain that results in decreased reality awareness and decrease in capacity to perform activities of daily living).</p> <p>Review of Resident 4's clinical record revealed that on October 1, 2023, Resident 4 was transferred to a hospital emergency room for concerns of chest pain. The Resident subsequently returned from the hospital to the facility on [DATE].</p> <p>During a staff interview on April 17, 2024, at approximately 1:30 PM, a request was made to the Nursing Home Administrator (NHA) and Director of Nursing (DON) for documentation that Resident 4 or Resident 4's Responsible Party was provided a copy of the facility's bed-hold policy upon transfer.</p> <p>During a staff interview on April 18, 2024, at approximately 11:30 AM, NHA and DON revealed that the facility did not have documentation that a bed-hold notice was provide for Resident 4's October 1, 2023, hospital transfer. During the interview, the NHA revealed that the facility was aware of concerns with bed-hold notices being provided at the time of transfer.</p> <p>Review of Resident 32's clinical record revealed diagnoses that included malignant neoplasm of colon (colon cancer) and chronic obstructive pulmonary disease (COPD - chronic inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>Further review of Resident 32's clinical record revealed he was transferred out to the hospital due to a change in condition on January 2, 15, and 28, 2024, and was subsequently admitted each time.</p> <p>Review of Resident 32's clinical record failed to reveal evidence that a bed-hold notice was provided to Resident 32 or his Representative at the times he was transferred to the hospital.</p> <p>(continued on next page)</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Per email correspondence received from the DON on April 17, 2024, at 10:12 AM ,she was not able to locate any evidence that a bed-hold notice was provided to Resident 32 or his Representative at the time of the aforementioned hospitalization s.</p> <p>Review of Resident 35's clinical record revealed diagnoses that included Schizoaffective Disorder (a mental health condition including schizophrenia and mood disorder symptoms) and anxiety.</p> <p>Further review of Resident 35's clinical record revealed that he was transferred and admitted to the hospital on February 2, 2024.</p> <p>On April 17, 2024, at 12:08 PM, the DON stated she was unable to locate the bed-hold transfer that was provided upon Resident 35's transfer to the hospital.</p> <p>Review of Resident 63's clinical record on April 17, 2024, at 8:52 AM, revealed diagnoses that included fracture of unspecified part of neck of left femur (type of hip fracture of the thigh bone) and acute posthemorrhagic anemia (condition that develops when you lose a large amount of blood quickly).</p> <p>Further review of Resident 63's clinical record revealed that on January 23, 2024, Resident 63 was admitted to the hospital.</p> <p>Review of Resident 63's clinical record failed to reveal that Resident 63 or Resident 63's Representative were provided the facility's bed-hold policy at the time of transfer or within 24 hours.</p> <p>During a staff interview on April 17, 2024, at 2:41 PM, with the NHA and DON, the surveyor requested a copy of the bed-hold policy provided to Resident 63 or Resident 63's Representative for the January 2024 hospitalization .</p> <p>During an additional staff interview on April 18, 2024, at 12:02 PM, with the NHA and DON, it was revealed the facility is unable to provide additional information. The DON, in the presence of the NHA, stated it had been identified that bed-hold policies were not being provided to residents or their representatives at the time of transfer, and that staff education had been provided. The NHA and DON stated that it was the expectation of the facility that bed-hold policy be given to the resident and resident representative at the time of transfer.</p> <p>Review of Resident 71's clinical record on April 15, 2024, at approximately 9:00 AM, revealed diagnoses that included dementia and atrial fibrillation (irregular heart beat).</p> <p>Review of Resident 71's clinical record revealed that on January 5, 2024, Resident 71 was transferred to the hospital emergency room after chest x-rays revealed possible pneumonia. Resident 71 returned to the facility from the hospital on January 9, 2024.</p> <p>During a staff interview on April 17, 2024, at approximately 1:30 PM, a request was made to the NHA and DON for documentation that Resident 71 or Resident 71's Responsible Party was provided a copy of the facility's bed-hold policy upon transfer.</p> <p>(continued on next page)</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a staff interview on April 18, 2024, at approximately 11:30 AM, NHA and DON revealed that the facility did not have documentation that a bed-hold notice was provide for Resident 71's January 9, 2024, hospital transfer. During the interview, the NHA revealed that the facility was aware of concerns with bed-hold notices being provided at the time of transfer.</p> <p>Review of Resident 72's clinical record revealed diagnoses that included Type 2 Diabetes Mellitus and unstageable left heel pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin).</p> <p>Further review of Resident 72's clinical record revealed that he was transferred and admitted to the hospital on December 5, 2023.</p> <p>During an interview with the DON on April 17, 2024, at 1:45 PM, she stated she was unable to provide a copy of the bed-hold transfer that was provided upon Resident 72's transfer to the hospital.</p> <p>Review of Resident 89's clinical record on April 18, 2025, at 9:15 AM, revealed diagnoses that included urinary tract infection (UTI - an infection caused by bacteria in any part of the urinary system) and acute and chronic respiratory failure with hypoxia (occurs when there is not enough oxygen in the blood).</p> <p>Further review of Resident 89's clinical record revealed Resident 89 was admitted to the hospital on December 12, 2023, and March 8, 2024.</p> <p>Review of Resident 89's clinical record failed to reveal that Resident 89 or Resident 89's Representative were provided the facility's bed-hold policy at the time of transfer or within 24 hours.</p> <p>During a staff interview on April 18, 2024, at 12:02 PM, with the NHA and DON, it was revealed the facility is unable to provide additional information. The DON, in the presence of the NHA, stated it had been identified that bed-hold policies were not being provided to residents or their representatives at the time of transfer, and that staff education had been provided. The NHA and DON stated that it was the expectation of the facility that bed-hold policy be given to the resident and resident representative at the time of transfer.</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p> <p>28 Pa Code 201.18(b)(3) Management</p> <p>28 Pa Code 201.29(a)(c.3)(2) Resident Rights</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37013</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that a comprehensive assessment was completed every 12 months, as required, for one of 103 residents (Resident 73).</p> <p>Findings include:</p> <p>Review of Resident 73's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and gout (a form of arthritis that causes severe pain, swelling, redness and tenderness in joints).</p> <p>Further review of Resident 73's clinical record revealed he had a comprehensive MDS assessment (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental, or psychosocial needs) completed on March 9, 2023.</p> <p>Review of Resident 73's MDS assessments revealed that Resident 73's comprehensive MDS assessment dated [DATE], has not yet been completed and was still in progress.</p> <p>Resident 73 has had no other comprehensive MDS assessments completed since March 9, 2023.</p> <p>On April 17, 2024, at 2:36 PM, the Nursing Home Administrator stated the facility has already identified an issue with MDS assessments not being completed timely.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37013</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that quarterly Minimum Data Set assessments were completed within the required timeframe for two of 103 residents (Residents 31 and 45).</p> <p>Findings include:</p> <p>Review of Resident 31's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure).</p> <p>Review of Resident 31's MDS assessments (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental, or psychosocial needs), revealed that Resident 31 had a quarterly MDS scheduled for March 15, 2024.</p> <p>Further review of Resident 31's MDS assessments revealed that Resident 31's quarterly MDS assessment dated [DATE], had four sections that had not yet been completed and was still in progress.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 17, 2024, at 2:36 PM, the NHA stated that the facility had already identified an issue with MDS assessments not being completed timely.</p> <p>During a final interview with the NHA and DON on April 18, 2024, at 11:22 AM, the NHA confirmed that she would expect MDSs to be completed and submitted in accordance to regulations.</p> <p>Review of Resident 45's clinical record revealed diagnoses that included COPD (chronic obstructive pulmonary disease - a group of lung diseases that block airflow and make it difficult to breathe) and hypertension.</p> <p>Review of Resident 45's MDS assessments, revealed that Resident 45 had a quarterly MDS completed on December 23, 2023.</p> <p>Further review of Resident 45's MDS assessments revealed that Resident 45's quarterly MDS assessment dated [DATE], had not yet been completed and was still in progress.</p> <p>On April 17, 2024, at 2:36 PM, the NHA stated that the facility has already identified an issue with MDS assessments not being completed timely.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37013</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to submit Minimum Data Set (MDS) assessments within the required timeframe (14 days following completion) for 13 of 103 residents reviewed (Residents 2, 3, 8, 14, 32, 33, 36, 56, 61, 66, 68, 86, and 97).</p> <p>Findings include:</p> <p>Review of Resident 2's clinical record revealed diagnoses that included Alzheimer's Disease and epilepsy (seizure disorder).</p> <p>Review of Resident 2's MDS assessments (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental, or psychosocial needs), revealed her quarterly MDS assessment dated [DATE], was not completed until April 9, 2024, and was accepted on April 12, 2024.</p> <p>Review of Resident 3's annual assessment dated [DATE], revealed it was not completed until January 20, 2024, and was not accepted until January 23, 2024.</p> <p>Review of Resident 3's quarterly MDS assessment dated [DATE], revealed it was completed, but had not yet been submitted as of April 18, 2024.</p> <p>Review of Resident 8's assessments revealed her quarterly MDS assessment dated [DATE], was not completed until April 9, 2024, and was not accepted until April 12, 2024.</p> <p>Review of Resident 14's assessments revealed her quarterly MDS assessment dated [DATE], was not completed until January 2, 2024, and was not accepted until January 5, 2024.</p> <p>Review of Resident 14's quarterly MDS dated [DATE], revealed it was completed, but had not been submitted as of April 18, 2024.</p> <p>Review of Resident 32's quarterly MDS dated [DATE], revealed it was not completed until March 4, 2024, and was not accepted until March 5, 2024.</p> <p>Review of Resident 33's quarterly assessment dated [DATE], revealed it was not completed until January 8, 2024, and was not accepted until January 11, 2024.</p> <p>Review of Resident 33's quarterly MDS dated [DATE], revealed it was completed, but had not been submitted as of April 18, 2024.</p> <p>Review of Resident 36's annual MDS dated [DATE], revealed it was not completed until April 12, 2024, and was not accepted until April 12, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 36's quarterly MDS dated [DATE], revealed it was completed, but had not been submitted as of April 17, 2024.</p> <p>Review of Resident 56's quarterly MDS dated [DATE], revealed it was not completed until January 8, 2024, and was not accepted until January 11, 2024.</p> <p>Review of his quarterly MDS dated [DATE], revealed it was completed on April 9, 2024, and was accepted on April 12, 2024.</p> <p>Review of Resident 61's annual MDS dated [DATE], revealed the assessment was not completed until January 27, 2024, and was not accepted until January 30, 2024.</p> <p>Review of Resident 61's quarterly MDS assessments dated March 12 and 22, 2024, revealed the assessments were completed, but had not been submitted as of April 18, 2024.</p> <p>Review of Resident 66's quarterly MDS dated [DATE], revealed it was not completed until January 6, 2024, and was not accepted until January 11, 2024.</p> <p>Review of Resident 66's quarterly MDS dated [DATE], revealed the assessment was completed, but had not been submitted as of April 18, 2024.</p> <p>Review of Resident 68's annual MDS dated [DATE], revealed the assessment was not completed and accepted until January 15, 2024.</p> <p>Review of Resident 86's quarterly MDS dated [DATE], revealed it was not completed until March 7, 2024, and was not accepted until March 10, 2024.</p> <p>Review of Resident 97's quarterly MDS dated [DATE], revealed it was not completed until January 20, 2024, and was not accepted until January 23, 2024.</p> <p>On April 17, 2024, at 2:36 PM, the Nursing Home Administrator stated that the facility has already identified an issue with MDS assessments not being submitted timely.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>33879</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for one of four residents reviewed for pressure injuries (Resident 60) and one of four residents reviewed for dementia care (Resident 86).</p> <p>Findings include:</p> <p>Review of Resident 60's clinical record on April 16, 2024, at approximately 10:20 AM, revealed diagnoses that included diabetes mellitus type 2 (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment) and stage III pressure injury (wound of the skin that extends through the layers of skin) of the sacral region.</p> <p>Review of Resident 60's clinical record revealed Resident 60 developed an unstageable pressure injury of the sacral region while a resident at the facility on November 16, 2023.</p> <p>Review of consultant wound physician's progress notes revealed the pressure ulcer remained unstageable until January 17, 2024, at which time the consultant wound physician assessed the pressure injury to be at stage III.</p> <p>Review of Resident 60's Quarterly Minimum Data Set (MDS - standardized assessment utilized to identify a residents physical, mental, and psychosocial needs), with an assessment reference date of January 30, 2024, revealed that subsection M0300-Current number of unhealed pressure ulcers/injuries at each stage was coded to reflect that Resident 60 had a stage III pressure injury that was not developed at the facility.</p> <p>During a staff interview on April 18, 2024, at approximately 11:30 AM, Nursing Home Administrator (NHA) confirmed that Resident 60's January 30, 2024, Quarterly MDS was coded incorrectly. During the interview, the NHA confirmed that the facility was in the process of submitting a corrected assessment.</p> <p>Review of Resident 86's clinical record revealed diagnoses that included dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life) with psychotic disturbance (loss of contact with reality) and depression (mood disorder that causes persistent feelings of sadness and loss of interest).</p> <p>Review of Resident 86's current care plan revealed a focus area for wandering/pacing due to cognitive impairment and restlessness, initiated on May 21, 2023.</p> <p>Review of nursing progress notes dates January 21, 2024, revealed Resident wandering around the unit throughout the shift being verbally abusive towards staff.</p> <p>Review of Resident 86's January 27, 2024, quarterly MDS revealed that the assessment was not coded to indicate that Resident 86 experienced wandering behavior in the lookback period (prior seven days).</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing on April 18, 2024, at 11:51 AM, she confirmed the assessment was incorrect and should have been coded to indicate Resident 86's wandering behavior.</p> <p>28 Pa code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>37013</p> <p>Based on observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for four of 29 residents reviewed (Residents 32, 72, 89, and 407).</p> <p>Findings include:</p> <p>Review of Resident 32's clinical record revealed diagnoses that included malignant neoplasm of colon (colon cancer) and chronic obstructive pulmonary disease (COPD - chronic inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>Review of nursing progress note dated April 1, 2024, revealed that Resident 32 was admitted to hospice (medical services, emotional support, and spiritual resources for people who are in the last stages of a terminal illness) on that date for malignant neoplasm of colon.</p> <p>Review of Resident 32's active care plan on April 17, 2024, failed to reveal any notation of hospice services.</p> <p>During an interview with the Director of Nursing (DON) on April 18, 2024, at 11:47 AM, she confirmed that Resident 32's care plan should have been updated with this information, and that it was now updated to reflect that Resident 32 was receiving hospice services.</p> <p>Review of Resident 72's clinical record revealed diagnoses that included Type 2 Diabetes Mellitus and unstageable left heel pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin).</p> <p>Review of Resident 72's current care plan revealed an intervention dated July 5, 2023, for pressure reduction boots while in bed.</p> <p>Observations of Resident 72 on April 15, 2024, at 8:40 AM, and April 18, 2024, at 10:23 AM, revealed Resident 72 in bed with a pressure reduction boot to his left foot only.</p> <p>During an interview with the DON on April 18, 2024, at 3:07 PM, she stated that Resident 72 refuses to wear the boot on the right foot. She stated that Resident 72's care plan should have been updated to reflect the refusal.</p> <p>Review of resident 89's clinical record on April 18, 2025, at 9:15 AM, revealed diagnoses that included urinary tract infection (UTI - an infection caused by bacteria in any part of the urinary system) and multiple sclerosis (long-lasting disease of the central nervous system).</p> <p>During a Resident interview on April 15, 2024, at 11:20 AM, Resident 89 reported having several UTIs since October 2023, and a urine culture that was positive for VRE (a type of bacteria called Enterococci that have developed resistance to many antibiotics, especially vancomycin)</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident 89's clinical record revealed a hospital discharge summary dated March 11, 2024.</p> <p>Review of the hospital discharge summary revealed Resident 89 had been hospitalized due to a complicated UTI, and returned to the facility with oral antibiotics.</p> <p>Review of Resident 89's physician progress notes revealed a note dated April 6, 2024, at 11:03 AM, that read, in part, resident with positive UA (urinalysis) C and S (culture and sensitivity) reviewed VRE isolated add Macrobid and use 100 mg bid for a week .</p> <p>Review of Resident 89's comprehensive plan of care revealed the facility failed to update the comprehensive care plan to include a focus area for UTI, antibiotic use, and the new identification of VRE in Resident 89's urine.</p> <p>During a staff interview April 18, 2024, at 11:53, with the Nursing Home Administrator (NHA) and DON, the surveyor requested additional information regarding revision of Resident 89's care plan.</p> <p>During an additional interview on April 18, 2024, at 2:36 PM, with the NHA, DON, and Employee 2, the DON stated that no additional information was available, and it was the facility's expectation that care plan revisions be done.</p> <p>Review of Resident 407's clinical record on April 17, 2024, at 2:31 PM, revealed diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and abnormalities of gait and mobility (difficulty walking).</p> <p>Review of Resident 407's comprehensive plan of care revealed a focus area of at risk for falls due to involuntary movements, unsteady gait and poor cognition, with an intervention for body pillow left side of bed.</p> <p>Observations on April 15, 2024, at 9:36 AM, and April 16, 2024, at 9:28 AM, of Resident 407, revealed body pillows tucked under the right and left side of Resident 407's fitted bed sheet.</p> <p>During a staff interview on April 17, 2024, at 2:42 PM, with the NHA and DON, the surveyor notified the NHA and DON of the two observations of body pillows on the left and right side of Resident 407's bed and requested additional information.</p> <p>During an additional interview on April 18, 2024, at 12:06 PM, with the NHA and DON, the DON stated she did not have any additional information, but would double check.</p> <p>During a final interview on April 18, 2024, at 2:40 PM, with the NHA, DON, and Employee 2, the DON stated it was determined Resident 407 needed two body pillows for positioning, and Resident 407's care plan should have been updated. The DON stated that it was the facility's expectation that care plan revisions be done timely.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>46253</p> <p>Based on facility policy review, observations, clinical record review, and staff interviews, it was determined that the facility failed to maintain adequate personal hygiene and grooming of residents dependent on staff for assistance with these activities of daily living for one of 23 residents reviewed (Resident 9).</p> <p>Findings include:</p> <p>Review of facility policy, titled Activities of Daily Living, Supporting, with a last revised date of March 2018, revealed, in part: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Review of Resident 9's clinical record revealed diagnoses that included cerebral infarction (a stroke - damage to the brain from interruption of its blood supply), abnormal posture, and stiffness of left hand.</p> <p>Review of Resident 9's care plan revealed a focus for ADL (Activities of Daily Living - washing face, brushing teeth, personal hygiene) Self-care deficit related to CVA (stroke), weakness, impaired gait and mobility, with a date initiated March 10, 2021. Interventions included, but were not limited to, extensive assistance with hygiene/grooming, dated March 10, 2021; and assist with daily hygiene, grooming, dressing, oral care and eating as needed, dated March 12, 2021.</p> <p>Observation of Resident 9 on April 15, 2024, at 9:30 AM, revealed that she was in her wheelchair in the unit common area. Her hair was disheveled and she had visible facial hair noted on her upper lip and chin.</p> <p>Observation of Resident 9 on April 16, 2024, at 9:38 AM, revealed that she was in her wheelchair in the unit common area. She still had visible facial hair noted to her upper lip and chin.</p> <p>Observation of Resident 9 on April 17, 2024, at 10:00 AM, revealed that she was in her wheelchair in the unit common area. She still had visible facial hair noted to her upper lip and chin.</p> <p>Further review of Resident 9's clinical record on April 17, 2024, at 10:00 AM, revealed in her nurse aide task documentation for personal hygiene from April 1 through 16, 2024, that she was documented as having received extensive to total assistance with personal hygiene on a daily basis, except for April 13, 2024.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (NHA) on April 17, 2024, at 2:01 PM, the aforementioned observations of Resident 9 were shared for follow-up.</p> <p>Follow-up review of Resident 9's clinical record on April 18, 2024, at 8:00 AM, revealed in her nurse aide task documentation for personal hygiene that there was no documentation of her having received any assistance with personal hygiene on April 17, 2024.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of Resident 9 on April 18, 2024, at 9:21 AM, revealed that she was in her wheelchair in the unit common area. She still had visible facial hair noted to her upper lip and chin.</p> <p>During a follow-up interview with the NHA and DON on April 18, 2024, at 11:18 AM, the DON indicated that the staff took care of Resident 9's facial hair last evening. Surveyor shared the aforementioned observation of Resident 9 at 9:21 AM. The DON indicated she would get it addressed. She also confirmed that she would expect staff to look at a resident's facial hair when providing care and complete if necessary. She also indicated that they probably need to look at this on a more frequent basis for female residents.</p> <p>28 Pa. Code 211.10(d) Resident Care Policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(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 - Some</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** 37013</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for three of 29 residents reviewed (Residents 31, 32, and 73).</p> <p>Findings include:</p> <p>Review of Resident 31's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure).</p> <p>Further review of Resident 31's clinical record revealed a POLST form (Pennsylvania Orders for Life Sustaining Treatment), dated [DATE], stating that if Resident 31 was found with no pulse and not breathing, Resident 31 wishes to have CPR/Full Treatment (full resuscitative measures).</p> <p>Review of Resident 31's physician orders revealed an order dated [DATE], for DNR (Do Not Resuscitate), meaning no CPR would be provided if Resident 31 was found without a pulse and not breathing.</p> <p>Review of Resident 31's clinical record progress notes revealed a note dated [DATE], at 1:56 PM, written by Social Services, that indicated a care plan meeting was held with the facility's interdisciplinary team and Resident 31's Representative, and that Resident 31's code status was discussed. The note further indicated In the system, she was a full code, but daughter shared that she should be a DNR. Nursing will take care of the discrepancy.</p> <p>During an interview with Employee 4 (Licensed Practical Nurse [LPN]) on [DATE], at 10:10 AM, Employee 4 stated she would go by the POLST since it was signed by Resident 31's physician. She further indicated that she was trained to go by the POLST, as this was what was actually signed by the doctor. She further confirmed that, based on the Social Service note dated [DATE], that Resident 31's POLST should have been changed.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on [DATE], at 1:56 PM, the DON stated that staff are trained to look at the POLST to determine a resident's code status in an emergent situation. She also confirmed that Resident 31's POLST should have been revised when the new order was obtained on [DATE].</p> <p>Review of Resident 32's clinical record revealed diagnoses that included malignant neoplasm of colon (colon cancer) and chronic obstructive pulmonary disease (COPD - chronic inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>Further review of Resident 32's clinical record revealed a POLST form dated [DATE], stating that if Resident 32 was found with no pulse and not breathing, Resident 32 wished to have CPR/Full Treatment (full resuscitative measures).</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 - Some</p>	<p>Review of Resident 32's physician orders revealed an order dated [DATE], for DNR, meaning no CPR would be provided if Resident 32 was found without a pulse and not breathing.</p> <p>Review of nursing progress note dated [DATE], revealed that Resident 32 was admitted to hospice for malignant neoplasm of the colon and that a new DNR order was written.</p> <p>During an interview with Employee 4 on [DATE], at 10:17 AM, she confirmed that Resident 32's code status changed when he began hospice services, and that his POLST should have been updated at that time.</p> <p>During an interview with the DON on [DATE], at 2:40 PM, she acknowledged the concern and confirmed that Resident 32's POLST had been updated to reflect his DNR status.</p> <p>Review of Resident 73's clinical record revealed diagnoses that included hypertension and gout (a form of arthritis that causes severe pain, swelling, redness and tenderness in joints).</p> <p>Further review of Resident 73's clinical record revealed a POLST form (Pennsylvania Orders for Life Sustaining Treatment), dated [DATE] with an illegible year, stating that if Resident 73 was found with no pulse and not breathing, Resident 73 wishes to be a DNR.</p> <p>Review of Resident 73's physician orders revealed an order dated [DATE], for Full Code, meaning CPR would be provided if Resident 73 was found without a pulse and not breathing.</p> <p>During an interview with Employee 3 (LPN) on [DATE], at 9:36 AM, Employee 3 stated that if she needed to determine a resident's code status in an emergent situation, she would look at the resident's dashboard in the computer and also at the resident's POLST form. At that time, Employee 3 was made aware of the discrepancy of Resident 73's physician order on the dashboard and POLST form. Employee 3 confirmed that Resident 73's dashboard stated full code and the POLST form stated DNR.</p> <p>In a follow-up interview with Employee 3 on [DATE], at 9:46 AM, she stated that she followed-up with Resident 73 and his wishes are to be a DNR.</p> <p>Review of Resident 73's updated physician orders revealed an order for DNR, dated [DATE].</p> <p>During an interview with the NHA and DON on [DATE], at 1:43 PM, the DON stated that staff are trained to look at the POLST to determine a resident's code status in an emergent situation.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p> <p>28 Pa. Code 211.10(a)(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>37013</p> <p>Based on observations, clinical record review, and staff interviews, it was determined that the facility failed to implement fall interventions for three of 29 residents reviewed (Residents 31, 35, and 72).</p> <p>Findings Include:</p> <p>Review of Resident 31's clinical record revealed diagnoses that included hypertension (elevated blood pressure), muscle weakness, lack of coordination, and repeated falls.</p> <p>Review of Resident 31's current fall care plan revealed an intervention, in part, dated November 20, 2023, for a scoop mattress (a mattress with edges that are built higher than the center to help keep a resident from rolling off) to be placed on bed for fall safety.</p> <p>Observations of Resident 31 in their bed on April 15, 2024, at 9:16 AM; April 16, 2024, at 9:52 AM; and April 17, 2024, at 8:25 AM; all failed to reveal the presence of scoop mattress on their bed.</p> <p>Observation was shared with Employee 2 on April 17, 2024, at 8:30 AM. She indicated that she would follow-up on the noted concern.</p> <p>Observation on Resident 31's room on April 17, 2024, at 12:10 PM, revealed that they were out of bed, and that a scoop mattress had been applied to their bed.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 17, 2024, at 1:52 PM, the DON confirmed that the scoop mattress should have been on Resident 31's bed as care planned.</p> <p>Review of Resident 35's clinical record revealed diagnoses that included Schizoaffective Disorder (a mental health condition including schizophrenia and mood disorder symptoms) and anxiety.</p> <p>Review of Resident 35's current fall care plan revealed an intervention dated January 16, 2024, for a fall mat on the left side.</p> <p>Observation of Resident 35 on April 17, 2024, at 11:09 AM, and April 18, 2024, at 8:01 AM, revealed Resident 35 in bed, with a fall mat on the right side of Resident 35's bed. Further observation failed to reveal a fall mat to the left side of Resident 35's bed.</p> <p>On April 18, 2024, at 12:05 PM, the NHA and DON were made aware of the observations of Resident 35's fall mat.</p> <p>On April 18, 2024, at 2:18 PM, the DON stated that Resident 35's care plan was correct and the fall mat has been moved to the left side.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 72's clinical record revealed diagnoses that included Type 2 Diabetes Mellitus and unstageable left heel pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin).</p> <p>Review of Resident 72's current fall care plan revealed an intervention dated March 22, 2024, for a fall mat to the left side of the bed.</p> <p>Observations on April 18, 2024, at 10:00 AM and 10:47 AM, revealed Resident 72 in bed, with a fall mat to the right side of his bed. Further observations failed to reveal a fall mat to the left side of the bed.</p> <p>During an interview with the DON on April 18, 2024, at 2:18 PM, she stated that Resident 72's care plan is correct and the fall mat has been moved to the left side of the bed.</p> <p>28 Pa code 211.12(d)(1)(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 - Some</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>46253</p> <p>Based on facility policy review, observations, clinical record review, and staff interviews, it was determined that the facility failed to ensure residents receive appropriate treatment and services to prevent urinary tract infections in residents with a foley catheter for one of one Residents reviewed (Resident 31).</p> <p>Findings include:</p> <p>Review of facility policy, titled Catheter Care, Urinary, with a last revision date of September 14, 2014, revealed, in part: The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder . be sure the tubing and catheter bag are kept off of the floor.</p> <p>The policy indicated step-by-step procedural instructions on how to perform catheter care, which included the following: cleansing of the genital and perineum with soap and water and rinsing well; using a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward; and that the following information should be documented in the resident's medical record, date and time catheter care was given; name and title of individual giving the catheter care, and all assessment data obtained when giving catheter care.</p> <p>Review of Resident 31's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure).</p> <p>Review of Resident 31's current physician orders revealed an order for an indwelling Foley Catheter (a flexible tube placed through the urethra to the bladder to drain urine) 18 French 30 cc (cubic centimeter) Balloon to straight bag gravity drainage for urinary retention, dated March 14, 2024.</p> <p>Further review of Resident 31's physician order revealed that her foley catheter was originally ordered on January 5, 2024.</p> <p>Further review of Resident 31's clinical record, including physician orders and treatment administration records from January 5, 2024, through April 18, 2024, failed to reveal any order or documentation of the provision of catheter care.</p> <p>Review of Resident 31's care plan revealed a care plan focus for use of indwelling urinary catheter related to urinary retention (difficulty urinating and completely emptying the bladder), dated March 14, 2024, with an intervention to maintain catheter drainage bag below bladder level.</p> <p>Further review of Resident 31's care plan history from January 5, 2024, through April 18, 2024, failed to reveal an intervention for the provision of catheter care.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of Resident 31 on April 15, 2024, at 11:29 AM, revealed that she was seated in her wheelchair in the common area of the unit. Her catheter bag was in a dignity cover and resting in her lap. Her lunch tray was delivered by a staff member at 11:35 AM.</p> <p>The aforementioned observation was shown to Employee 4 (Licensed Practical Nurse), who confirmed that Resident 31's urinary drainage bag should not have been in her lap. Employee 4 directed another staff member to correct the concern.</p> <p>Review of Resident 31's clinical record progress notes revealed that a nurse's note dated April 17, 2024, at midnight, that indicated her foley bag noted to not have any urine in it and brief was saturated at end of 3-11 shift. Tinge of bloody urine noted in foley bag. Foley catheter changed as ordered and resident tolerated well. Catheter with 30 cc nss [normal saline solution] removed and catheter removed, was brown in color. Resident noted to have white chunky discharge and red rash to groin. New catheter inserted 18 fr [French] using sterile technique and balloon inflated with 30 cc nss. Foley began draining thick cloudy yellow urine. Urine obtained for UA [urinalysis] C & S [culture and sensitivity]. RN [Registered Nurse] updated.</p> <p>Observation of Resident 31 on April 17, 2024, at 8:26 AM, revealed that her urinary drainage bag was lying directly on the floor.</p> <p>The aforementioned observation of Resident 31 was shown to Employee 2 (Corporate Clinical Nurse) on April 17, 2024, at 8:30 AM. Employee 2 confirmed that the urinary drainage bag was on the floor, but stated it could have fallen off the bed frame. She corrected the concern.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 17, 2024, at 2:24 PM, the DON confirmed that Resident 31's catheter bag should not have been laying on her lap or on the floor. At that time, the surveyor requested Resident 31's urinalysis results.</p> <p>Observation of Resident 31 on April 18, 2024, at 9:19 AM, revealed that her urinary drainage bag was laying her bed beside her left lower leg.</p> <p>Review of Resident 31's urinalysis results on April 18, 2024, at 10:31 AM, revealed several abnormalities indicative of an urinary tract infection, including blood, elevated white blood cells, and high leukocyte esterase (high level of white blood cells in the urine). The urine also showed a high level of yeast present in the urine.</p> <p>During an interview with the NHA and DON on April 18, 2024, at 11:21 AM, the DON confirmed that Resident 31's urinary drainage bag should not be laying on the Resident's bed, as this puts the drainage bag on the same plane [level] as the bladder. In addition, the aforementioned findings in Resident 31's nurse's note from April 17, 2024, was discussed and concern was shared that no documentation could be located regarding the provision of catheter care. The DON indicated that Resident 31 was now being treated for both a yeast infection and an urinary tract infection. The surveyor requested any additional information regarding catheter care.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a final interview with the NHA, DON, and Employee 2 on April 18, 2024, at 2:23 PM, the DON confirmed that catheter care was not added in task or treatment documentation when Resident 31's catheter was originally ordered. She indicated that she had no additional information to offer regarding the provision of Resident 31's catheter care. She further indicated that this had now been added. The DON confirmed that she would expect that the Residents with catheters would receive catheter care and documentation be completed.</p> <p>28 Pa code 211.12(d)(1)(2)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>49123</p> <p>Based on observation, clinical record review, and staff interviews, it was determined that the facility failed to ensure that respiratory care and services provided were consistent with professional standards of care for one of two residents reviewed for respiratory care (Resident 407).</p> <p>Findings include:</p> <p>Review of facility policy, titled Oxygen Administration, with a revision date of October 2010, revealed 1. Verify that there is a physician's order for this procedure.</p> <p>Review of Resident 407's clinical record on April 18, 2024, at 10:57 AM, revealed diagnoses of metabolic encephalopathy (an alteration in consciousness caused due to brain dysfunction) and chronic diastolic (congestive) heart failure (a condition in which the heart's left ventricle becomes stiff and unable to fill properly).</p> <p>During an interview on April 15, 2024, at 9:35 AM, with Resident 407, an observation was made of Resident 407 receiving supplemental oxygen via nasal canula at 2.5 liters (of oxygen) per minute.</p> <p>An additional observation was made on April 16, 2024, at 11:13 AM, of the oxygen tubing and nasal canula lying in bed bedside Resident 407. The oxygen concentrator (medical device that gives you extra oxygen) was running and set at 2.5 liters (of oxygen) per minute.</p> <p>Review of Resident 407's physician orders revealed Resident 407 had no physician order for supplemental oxygen.</p> <p>During a staff interview April 18, 2024, at 12:06 PM, with the Nursing Home Administrator (NHA) and Director of Nursing (DON), the surveyor requested additional information regarding Resident 407's supplemental oxygen use without a physician's order.</p> <p>During an additional staff interview on April 18, 2024, at 2:39 PM, with the NHA, DON, and Employee 2, the DON stated that on April 13, 2024, Resident 407 had an episode of low oxygen saturation (measurement of oxygen in the blood) and was placed on supplemental oxygen. The DON also stated she was informed the nurse received a verbal order from the physician for supplemental oxygen, but failed to enter the order or document that the physician was notified. The DON stated she did not have additional information as to why Resident 407 remained on supplemental oxygen April 15 and 16, 2024. The NHA and DON stated it was the facility's expectation that orders be obtained and entered for supplemental oxygen use.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>40010</p> <p>Based on review of facility policy, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that the residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of 30 residents reviewed (Resident 80).</p> <p>Findings include:</p> <p>Review of facility policy, titled Trauma Informed Care, revised March 2019, revealed, Purpose: To guide staff in appropriate and compassion care specific to individuals who have experienced trauma.</p> <p>Review of Resident 80's clinical record revealed diagnoses that included Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event. The condition may last months or years, with triggers that can bring back memories of the trauma, accompanied by intense emotional and physical reactions) and depression (a group of conditions associated with the elevation or lowering of a person's mood).</p> <p>Review of Resident 80's care plan on April 17, 2024, failed to reveal any plan of care regarding treatment of Resident 80's trauma.</p> <p>Review of Resident 80's medical record on April 17, 2024, failed to reveal any screening or evaluation of Resident 80's history of trauma.</p> <p>Interview with Resident 80 on April 18, 2024, at 10:34 AM, revealed that the Resident had a history of trauma, and that the Resident did not recall being evaluated for the trauma since being admitted to the facility.</p> <p>Interview with the Director of Nursing on April 18, 2024, at 11:15 AM, revealed that the Resident would be evaluated and that a care plan would be added to better provide care for Resident 80 regarding the Resident's history of trauma.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>37116</p> <p>Based on review of select facility documentation and staff interview, it was determined that the facility failed to ensure that nurse aide performance evaluations were completed at least annually and that in-service education was provided based on the outcome of these reviews for five of five nurse aides reviewed (Employees 5, 6, 7, 8, and 9).</p> <p>Findings Include:</p> <p>Review of select facility documentation revealed that Employee 5 was hired in 2015; Employee 6 was hired in 2022; Employee 7 was hired in 2018; Employee 8 was hired in 2009; and Employee 9 was hired in 2008.</p> <p>Review of facility-provided employee performance evaluations for Employees 5, 7, 8, and 9 revealed: one was completed on February 20, 2019, for Employee 5; one was completed on July 28, 2019, for Employee 7; one was completed in December 2021 for Employee 8; and one was completed on March 23, 2023, for Employee 9. No performance evaluation was provided for Employee 6.</p> <p>During an interview with the Nursing Home Administrator on April 19, 2024, at 11:59 AM, she acknowledged that the nurse aide performance evaluations were not timely. She also confirmed that all evaluations that could be located were provided.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(3) Management</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>37116</p> <p>Based on clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to ensure Medication Regimen Reviews were completed by a consultant pharmacist, responded to in a timely manner by the attending physician or prescriber, and that a rationale was provided for any declined recommendations for five of five residents reviewed for unnecessary medications (Residents 27, 32, 86, 89, and 407).</p> <p>Findings include:</p> <p>Review of facility policy, titled Medication Regimen Reviews, revised May 2019, revealed, The consultant pharmacist reviews the medication regimen of each resident at least monthly .The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it.</p> <p>Review of Resident 27's clinical record revealed diagnoses that included diabetes (a group of endocrine diseases that cause high blood sugar levels) and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>Review of Resident 27's electronic medical record on April 17, 2024, failed to reveal any evidence that Resident 27 had a pharmacist review their medication regimen for the months of July, September, October, and December of 2023.</p> <p>An interview with the Director of Nursing (DON) on April 18, 2024, at 10:30 AM, revealed that they do not have any documents to show that a pharmacist reviewed their medication regimen for the months of July, September, October, and December of 2023.</p> <p>Review of Resident 32's clinical record revealed diagnoses that included schizoaffective disorder (condition in which a person experiences a combination of schizophrenia symptoms - such as hallucinations or delusions - and mood disorder symptoms, such as mania or depression) and dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life).</p> <p>Further review of Resident 32's clinical record revealed progress notes on July 7, 2023; February 12, 2024; March 11, 2024; and April 9, 2024, indicating that the Resident was reviewed by the consultant pharmacist and recommendations were made.</p> <p>Review of available clinical documentation failed to reveal what aforementioned recommendations were made.</p> <p>During an interview with the DON on April 18, 2024, at 2:38 PM, she revealed that they were not able to locate any additional information regarding Resident 32's aforementioned pharmacy recommendations.</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>Review of Resident 86's clinical record revealed diagnoses that included dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life) with psychotic disturbance (loss of contact with reality) and depression (mood disorder that causes persistent feelings of sadness and loss of interest).</p> <p>Further review of Resident 86's clinical record revealed progress notes on May 5, 2023; July 7, 2023; and October 2, 2023, indicating that the Resident was reviewed by the consultant pharmacist and recommendations were made.</p> <p>Review of available clinical documentation failed to reveal what aforementioned recommendations were made.</p> <p>During an interview with the DON on April 18, 2024, at 2:38 PM, she revealed that they were not able to locate any additional information regarding Resident 86's aforementioned pharmacy recommendations.</p> <p>Review of Note to Attending Physician/Prescriber form for Resident 86, dated August 7, 2023, revealed the following recommendation was made by the consultant pharmacist: The resident is receiving Gabapentin 100 mg [used to treat neuropathic pain] 3 times a day. In an effort to eliminate unnecessary medications and prevent possible side effects associated with them, please evaluate their current pain management regimen. Consider a trial reduction or discontinuation, if appropriate. If this medication must be continued, please provide the risk vs. benefit rationale. Further review of the form revealed that the physician marked the box, indicating that he disagreed with this recommendation, but documented no rationale for the disagreement.</p> <p>Review of Note to Attending Physician/Prescriber form for Resident 86, dated September 8, 2023, revealed the following recommendation was made by the consultant pharmacist: The resident has been receiving Ativan 0.5 mg [antianxiety medication] 2 times a day and every 4 hours as needed; Risperdal 0.5 mg [antipsychotic medication] 2 times a day; ABH 1/12.5/1 mg [combination drug that can be used to treat agitation] every 4 hours as needed .Please consider an attempted dose reduction or trial discontinuation, as you deem appropriate. If gradual dose reduction [GDR] is clinically contraindicated at this time, please document the clinical rationale below. This must address the reason(s) why an attempted GDR would likely impair the resident's function or cause psychiatric instability, by exacerbating an underlying medical or psychiatric disorder. Further review of the form revealed that the physician marked the box indicating that he disagreed with this recommendation, but documented no rationale for the disagreement.</p> <p>During an interview with the DON on April 18, 2024, at 11:56 PM, she revealed the expectation that the physician would document some rationale when disagreeing with a pharmacy recommendation.</p> <p>Review of Resident 89's clinical record on April 17, 2024, at 2:38 PM, revealed diagnoses that included anxiety disorder (a constant state of worry, fear, and dread) and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</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>Review of Resident 89's monthly pharmacy reviews revealed that on September 12, 2023; October 3, 2023; November 6, 2023; December 7, 2023; January 10, 2024; and March 10, 2024, a recommendation was made by the pharmacist. No evidence was revealed that a pharmacy review was completed for the months of July 2023 and August 2023.</p> <p>During a staff interview on April 17, 2024, at approximately 2:38 PM, with the Nursing Home Administrator (NHA) and DON, the surveyor requested additional information regarding pharmacy reviews for July 2023 and August 2023, a copy of the pharmacy recommendations, and the physician's responses.</p> <p>During an additional staff interview on April 18, 2024, at 12:00 PM, with the NHA and DON, the surveyor made a second request for additional information regarding pharmacy reviews for July 2023 and August 2023, a copy of the aforementioned pharmacy recommendations, and the physician's responses.</p> <p>On April 18, 2024, at 1:55 PM, the facility provided a copy of the pharmacy recommendations for October 3, 2023, and December 7, 2023.</p> <p>Review of the pharmacy recommendations failed to reveal physician acknowledgement or signature for the October 2023 and December 2023 pharmacy recommendations.</p> <p>During a final staff interview on April 18, 2024, at 2:32 PM, with the NHA, DON, and Employee 2, it was revealed the facility was unable to provide any additional information on pharmacy reviews, pharmacy recommendations, and physician responses.</p> <p>Review of Resident 407's clinical record on April 17, 2024, at 9:58 AM, revealed diagnoses that included unspecified dementia (A condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems) and anxiety disorder (a constant state of worry, fear, and dread).</p> <p>Review of Resident 407's monthly pharmacy reviews revealed that on April 9, 2024, a recommendation was made by the pharmacist.</p> <p>During a staff interview on April 17, 2024, at 2:40 PM, with the NHA and DON, the surveyor requested a copy of the pharmacy recommendation and the physician's response.</p> <p>During an additional staff interview on April 18, 2024, at 12:10 PM, with the NHA and DON, the surveyor again requested a copy of the pharmacy recommendation and the physician's response. The DON stated she would provide a copy.</p> <p>During a subsequent staff interview on April 18, 2024, at 2:35 PM, with the NHA, DON, and Employee 2, the surveyor made a third request for the pharmacy recommendation and the physician's response. The DON again said she would provide a copy.</p> <p>During a final interview on April 18, 2024, at 3:08 PM, with the NHA, DON, and Employee 2, the DON stated there was no further information available.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</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>28 Pa. Code 211.10(c) Resident care policies</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>37116</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure as needed antipsychotic drugs were evaluated and renewed every 14 days for one of five residents reviewed for unnecessary medications (Resident 86).</p> <p>Findings include:</p> <p>Review of Resident 86's clinical record revealed diagnoses that included dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life) with psychotic disturbance (loss of contact with reality) and depression (mood disorder that causes persistent feelings of sadness and loss of interest).</p> <p>Review of Resident 86's current active physician orders revealed an order for ABH gel (combination medication consisting of Ativan [antianxiety medication], Benadryl [antihistamine], and Haldol [antipsychotic medication]) every four hours as needed for agitation, effective April 21, 2023, and no documented end date.</p> <p>Review of Resident 86's clinical record failed to reveal evidence that the order for ABH gel was reviewed for appropriateness after 14 days.</p> <p>During an interview with the Director of Nursing (DON) and Nursing Home Administrator on April 18, 2024, at 2:38 PM, the DON revealed that the physician intended to continue use of the ABH gel. They also expressed understanding that orders for antipsychotic medications must be reviewed for continued use every 14 days.</p> <p>28 Pa. Code 211.2(d)(3) Medical Director</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>46253</p> <p>Based on review of facility policy, test tray completion, review Resident Council Meeting minutes, and resident and staff interviews, it was determined that the facility failed to provide beverages that are palatable and at a safe and appetizing temperature for one of one meal observed on the Evergreen Way hall.</p> <p>Findings include:</p> <p>Review of facility policy, titled Food Preparation and Service, with a last revised date of April 2019, revealed, in part, the following: Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices.</p> <p>In section titled Food Preparation, Cooking and Holding Time/Temperatures, revealed 1. The 'danger zone' for food temperatures is between 41 degrees Fahrenheit and 135 degrees Fahrenheit. This temperature range promotes rapid growth of pathogenic microorganisms that cause foodborne illness. 2. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt, and cottage cheese. 3. The longer foods remain in the 'danger zone' the greater the risk for growth of harmful pathogens. Therefore, PHF [potentially hazardous foods] must be maintained below 41 degrees Fahrenheit or above 135 degrees Fahrenheit.</p> <p>During an interview with Resident 35 on April 15, 2024, at 10:23 AM, revealed that their food was cold at times.</p> <p>During an interview with Resident 45 on April 15, 2024, at 12:00 PM, revealed that the food trays sit in food carts for an extended amount of time, and that the food gets cold and the ice cream melts.</p> <p>During an interview with Resident 77 on April 15, 2024, at 8:52 AM, revealed that their food was often cold.</p> <p>During an interview with Resident 87 on April 15, 2024, at 8:02 AM, revealed that their food was often cold.</p> <p>During an interview with Resident 96 on April 15, 2024, at 10:44 AM, revealed that their food was cold every day.</p> <p>Review of the Resident Council Meeting minutes for January 2024, February 2024, and March 2024, revealed each month the resident group had voiced concerns regarding food temperatures.</p> <p>A test tray was completed on April 17, 2024, at 11:27 AM, in the Evergreen Way hall. Test tray temperatures were taken by Employee 1 (Certified Dietary Manager) on the tray that had been prepared for Resident 43, at approximately 11:31 AM, and revealed the following:</p> <p>Pureed Fruited Jello 55 degrees Fahrenheit (F), not palatable temperature;</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Chocolate Milk (honey thickened) 53 degrees F, not palatable temperature; and</p> <p>Water (honey thickened) 54 degrees F, not palatable temperature.</p> <p>During an interview with Employee 1 on April 17, 2024, at 11:37 AM, they indicated that food and beverage temperatures are based on resident palatability. Some resident's don't like their foods as hot or their cold beverages as cold as the temperature guidelines. The surveyor share the concerns with the temperatures and that several residents had voiced complaints about the food temperatures.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing on April 17, 2024, at 2:10 PM, the NHA confirmed that the beverage temps were a little on the high side. The NHA also shared that the facility had recently purchased a pellet warmer to help maintain the temperatures of hot food items, but were still awaiting one additional piece of equipment and then staff would be trained on proper usage.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</p> <p>28 Pa. Code 201.8(b)(1) Management</p> <p>28 Pa. Code 211.6 Dietary Services</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>46253</p> <p>Based on resident and staff interviews, it was determined that the facility failed to provided food per resident preference for two of 24 residents observed (Residents 96 and 358).</p> <p>Findings include:</p> <p>During an interview with Resident 96 on April 15, 2024, at 10:44 AM, the Resident indicated that they only receive 1% milk and would prefer to have 2% or whole milk. The Resident further indicated that they had spoken to Employee 1 (Certified Dietary Manager) regarding their preference, and was told by Employee 1 that the facility can only get 1% from their supplier.</p> <p>During an interview with Resident 358 on April 15, 2024, at 10:46 AM, the Resident indicated that they only receive 1% milk and would prefer to have 2% or whole milk. The Resident also indicated that they had spoken to Employee 1 regarding their preference, and was told by Employee 1 that the facility can only get 1% from their supplier.</p> <p>During an interview with Employee 1 on April 18, 2024, at 9:47 AM, they indicated that there was a national shortage on paper milk cartons and that they can only get 1% in the individual cartons. When asked if the facility could purchase a larger container of whole or 2% milk to honor a residents' preferences, Employee 1 stated if we start doing it for one then they will all want it and we can't be pouring it for all the residents.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 18, 2024, at 11:30 AM, the aforementioned resident and staff interviews were shared. Both the NHA and DON confirmed that there had been discussions regarding the matter, and that the owner of the facility had also spoken to Resident 358 regarding his preference. The DON indicated that, based on their last discussion, she thought that the kitchen was going to be purchasing a half-gallon or gallon of either whole or 2% milk to provide. The DON confirmed that the kitchen staff do pour other beverages into individual serving glasses. The NHA confirmed that the facility should make reasonable efforts to accommodate resident preferences. The NHA and DON indicated that they were only aware of one resident requesting whole or 2% milk. The surveyor shared the two residents that voiced the preference, and the DON indicated that she would follow-up to see that Residents 96 and 358 get their preferences addressed.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy</p> <p>28 Pa code 211.6(c) Dietary Services</p>		

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NAME OF PROVIDER OR SUPPLIER Forest Park Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Walnut Bottom Road Carlisle, PA 17013	
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 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>37013</p> <p>Based on observations, clinical record review, and staff interviews, it was determined that the facility failed to provide adaptive feeding devices for two of 29 residents reviewed (Residents 9 and 35).</p> <p>Findings Include:</p> <p>Review of Resident 9's clinical record revealed diagnoses that included cerebral infarction (a stroke - damage to the brain from interruption of its blood supply), abnormal posture, and stiffness of left hand.</p> <p>Review of Resident 9's physician orders revealed a diet order that included a Kennedy cup with meals, dated February 4, 2024.</p> <p>Review of Resident 9's current care plan revealed a care plan focus for being at risk for altered nutrition with an intervention for Kennedy cup, with a revision date of May 27, 2021.</p> <p>Observation of Resident 9 at lunch on April 15, 2024, at 11:55 AM, revealed that a Kennedy cup was present on her meal tray, but was turned upside down with no beverage ever poured into the cup. She had three small plastic beverage cups, each containing a beverage.</p> <p>Observation of Resident 9 at breakfast on April 16, 2024, at 8:03 AM, revealed that a Kennedy cup was not present on her meal tray. She had milk, juice, and water in small plastic beverage cups. She was observed drinking the juice.</p> <p>Observation of Resident 9 at breakfast on April 17, 2024, at 8:06 AM, revealed that a Kennedy cup was present on her meal tray, but was turned upside down with no beverage ever poured into the cup. She had three small plastic beverage cups, each containing a beverage.</p> <p>Observations of Resident 9 was shared with Employee 2 on April 17, 2024, at 8:32 AM, for further follow-up. Employee 2 indicated that they would follow-up with the nursing staff.</p> <p>A follow-up observation of Resident 9 at lunch on April 17, 2024, at 12:00 PM, revealed that she had one Kennedy cup containing a beverage, as well as three small plastic beverage cups each containing a beverage.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 17, 2024, at 2:00 PM, the DON indicated that they had spoken with staff regarding Resident 9's use of the Kennedy cup, and that the nursing staff reported that Resident 9 does not like to use the Kennedy cup. The DON further indicated that they would be reviewing this.</p> <p>During a final interview with the NHA and DON on April 18, 2024, at 2:20 PM, the DON indicated that staff had not reported the Resident not liking to use the Kennedy cup prior to surveyor observations.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 35's clinical record revealed diagnoses that included Schizoaffective Disorder (a mental health condition including schizophrenia and mood disorder symptoms) and anxiety.</p> <p>Review of Resident 35's current care plan revealed an intervention dated January 16, 2024, for adaptive equipment- Kennedy cup.</p> <p>Review of Resident 35's current physician orders revealed a diet order dated February 6, 2024, for Resident 35 to have a Kennedy cup with meals.</p> <p>Review of Resident 35's meal ticket revealed Kennedy cup was listed under the adaptive equipment.</p> <p>Observation of Resident 35 on April 17, 2024, at 11:09 AM, revealed Resident 35 eating lunch in bed. Further observation revealed Resident 35's Kennedy cup turned upside down on his lunch tray, not being used. Resident 35's drinks were in regular cups.</p> <p>Observation of Resident 35 on April 18, 2024, at 8:01 AM, revealed Resident 35 eating breakfast in bed. Further observation revealed Resident 35's Kennedy cup turned upside down on his breakfast tray, not being used.</p> <p>Observation at 8:20 AM, at the conclusion of Resident 35's breakfast meal, revealed the Kennedy cup remained upside down and had not been used.</p> <p>On April 18, 2024, at 12:05 PM, the NHA and DON were made aware of the observations of Resident 35's Kennedy cup remaining upside down on his lunch and breakfast trays.</p> <p>On April 18, 2024, at 2:20 PM, the DON stated that Resident 35 does not like to use the Kennedy cup and he will be reevaluated regarding the use of a Kennedy cup. At that time, the DON also stated that Resident 35 should have been reevaluated prior, since it has been determined that he does not like to use the Kennedy cup.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</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>46253</p> <p>Based on observations, policy review, select document review, and staff interviews, it was determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the kitchen, in three of three nursing unit refrigerators, and one of two ice machines (Evergreen Way/Stepping Stones unit).</p> <p>Findings include:</p> <p>Review of facility policy, titled Food Receiving and Storage, with a last revised date of October 2017, revealed, in part: 1. Food services, or other designated staff, will maintain clean food storage areas at all times. 8. All foods stored in the refrigerator or freezer will be covered, labeled, and dated ('use by' date). 14. Food items and snacks kept on the nursing units must be maintained as indicated below: a. All food items . must be labeled with a 'use by' date. b. All foods belonging to a residents must be labeled with the resident's name, the item and the 'use by' date. e. Other opened containers must be dated and sealed or covered during storage. g. Medications .may not be stored in the same refrigerator with food.</p> <p>Review of facility policy, titled Refrigerators and Freezers, with a last revised date of December 2014, revealed, in part: 7. All food shall be appropriately dated to ensure proper rotation by expiration dates. 'Received dates' (dates of delivery) will be marked on cases and on individual items removed from cases for storage. 'Use by' dates will be completed with expiration dates on all prepared foods in refrigerators. Expiration dates on unopened food will be observed and 'use by' dates indicated once food is opened. 9. Supervisors will inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. 10. Refrigerators and freezers will be kept clean, free of debris, and mopped with a sanitizing solution on a scheduled basis and more often as necessary.</p> <p>Review of facility policy, titled Sanitization, with a last revised date of October 2008, revealed, in part: 1. All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, and flies and other insects.</p> <p>Review of facility policy, titled Dishwashing Machine Use, with a last revision date of March 2010, revealed, in part: 2. Dishwashing machines that use hot water to sanitize must maintain the following wash solution temperatures: a. 150 degrees Fahrenheit for stationary rack, dual temperature machines; 3. Dishwashing machine hot water sanitation rinse temperatures may not be more than 194 degrees Fahrenheit, or less than b.180 degrees Fahrenheit, except for stationary rack single temperature machines. The policy continued, 7. The operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log Inadequate temperatures will be reported to the supervisor and corrected immediately. 9. If hot water temperatures or chemical solution concentrations do not meet requirements, cease use of the dishwashing machine immediately until temperatures or PPM [parts per million-referring to the chemical sanitation solution] are adjusted.</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>Initial tour of kitchen and all nourishment rooms were completed by the surveyor with Employee 1 (Certified Dietary Manager) present on April 15, 2024.</p> <p>Observation of the dry storage area in the kitchen on April 15, 2024, at 7:22 AM, revealed the following: under the metal shelving unit near the wall was a black substance on the floor; an onion on the floor with a sprout that measured approximately 6 inches sticking up through the open shelving unit; two cans of soda and a bottle of juice on the floor under the shelving units; three 1-gallon mustard containers (one opened) that all had a use by date of April 4, 2024; a bottle of syrup not dated when opened; and a can of diced tomatoes, banana pudding, and mandarin with no received date indicated.</p> <p>Observation of the beverage area on April 15, 2024, at approximately 7:30 AM, revealed a dish storage cart in which all dishes were stored upright and uncovered, and there was a plate and a bowl noted with debris. The cart also had visible debris on the inside of the bottom of the cart.</p> <p>Observation of the food preparation/cooking area on April 15, 2024, at approximately 7:33 AM, revealed a vent on the wall by a door that had a heavy build-up of a black colored debris inside; and the oven had a heavy grease build-up on the outside of the doors and knobs.</p> <p>Observation of the cooks' cooler on April 15, 2024, at approximately 7:37 AM, revealed cheese that was dated as being opened on April 7, 2024, and to be used by April 14, 2024; which Employee 1 discarded and indicated it was not dated properly. In addition, there were two small metal bins labeled as riblets but were not dated. Employee 1 indicated that these were left over from April 13, 2024.</p> <p>Observation of the Laurel Lane nourishment room on April 15, 2024, at 7:49 AM, revealed the freezer had slight food debris noted. Further, the refrigerator had a red, sticky substance on the shelving; a yellow, sticky substance on the base of refrigerator; the insulated gasket molding at the bottom of the door was busted; rust noted on the bottom of the refrigerator; food debris was present in the recessed door handles and in the rubber insulated gasket molding; and the microwave had a moderate amount of food splatter. During an immediate interview with Employee 1, she indicated that kitchen staff stock the refrigerators daily and that they will wipe up spills if noted, but that nursing should be cleaning the refrigerators routinely. Employee 1 indicated that housekeeping should be cleaning the microwaves. Employee 1 further indicated that she would get someone to clean the refrigerator and microwave.</p> <p>Observation of the Evergreen Way/Stepping Stones nourishment room on April 15, 2024, at 7:52 AM, revealed that the freezer had a light brown discoloration; a red and yellow, dried, sticky appearing residue on the refrigerator shelves; a heavy, yellow food splatter in the microwave; a personal tote bag in the cabinet; and a drawer with miscellaneous items such as loose cup lids, a pencil, and loose coffee filters.</p> <p>Observation of the ice machine on Evergreen Way/Stepping Stones on April 15, 2024, at 7:57 AM, revealed that the ice scoop was slightly laying out of its storage bin and resting directly on the top of the ice machine. There were small black spots on the inside of the ice machine lid, but was not in direct contact with the. The wall had some patchwork completed, and the floor had some black staining noted.</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>Observation of the Chapelwood nourishment room on April 15, 2024, at 7:58 AM, revealed a brown spill in the freezer; a large amount of a red sticky residue on the shelf; a plastic bag that contained a Caesar salad kit, a bottle of generic MiraLAX, carrots, and cranberry juice, none of which had a name or date; a plate of three hot dog rolls containing some type of meat that was dated 4/14, but the clear plastic wrap was peeled back and one of the hot dog rolls directly exposed; a container of garlic butter with no name or date, but manufacturer sell by date was 2/1/2024; and a large stain on the floor in front of refrigerator that was a sticky brown substance with food crumbs adhered. Employee 1 discarded the plastic bag of items as mentioned above.</p> <p>Observation of the Evergreen Way ice machine on April 16, 2024, at 9:54 AM, revealed that the black substance remained on the inside lid of the ice machine.</p> <p>Observation of the dish machine on April 16, 2024, at 12:44 PM, revealed that the wash temperature was 130 degrees Fahrenheit (F) and the rinse temperature was 160 degrees F. Temperatures were verified by Employee 1. She further indicated that she did not think the gauges were working properly because the temperature gauge did not seem to move during the cycle. She further indicated that it was working earlier. Employee 1 then called maintenance to come and check the dishwasher. Employee 10 (Maintenance Worker) came to the kitchen and ran the machine, and also confirmed that the proper temperatures were not being reached and suggested to Employee 1 call the outside service provider.</p> <p>Continued observation of the dish machine on April 16, 2024, at 12:51 PM, revealed the wash temperature was 130 degrees F, and the rinse temperature was 154 degrees F. Employee 1 again stated it was ok at breakfast.</p> <p>Review of the Dish Machine Temperature Log for April 2024, on April 16, 2024, at 12:52 PM, revealed instructions that stated, The wash temperature must be at least 150 degrees and the final rinse temperature at least 180 degrees. IF the temperature is not at the proper temperature DO NOT USE THE MACHINE-notify your supervisor for instructions. The temperature check for breakfast on April 16, 2024, had temperatures recorded, but were scribbled out. The temperatures appeared to read a wash temperature of 149 degrees F and a rinse temperature of 178 degrees F. There had been no lunch temperatures recorded.</p> <p>On April 16, 2024, at 12:55 PM, Employee 1 ran a metal thermometer through the dish machine while the surveyor and Employee 10 were present. When Employee opened door to the dish machine and immediately read the temperature, it registered 145 degrees F. Employee 10 again indicated to Employee 1 to call the outside vendor.</p> <p>On April 16, 2024, at 12:57 PM, Employee 1 made a call to the outside service provider for an emergency work order.</p> <p>Further review of the Dish Machine Temperature Log for April 2024, revealed the following concerns: the lunch wash temperature for April 15, 2024, appeared to be 147 degrees F, but the number 4 had been altered/written over with what appeared to be the number 6; there was no dinner temperature recorded for April 15, 2024; and the rinse temperature was recorded as less than 180 degrees F for the following: April 1, 2024, for breakfast (172 degrees F) and lunch (170 degrees F); April 2, 2024, for breakfast (172 degrees); April 8, 2024, for lunch (161 degrees) and on April 9, 2024, for dinner (160 degrees, but the number had been written over).</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>There was no observation that dietary staff were instructed to stop using the dish machine.</p> <p>During a follow-up interview with Employee 1 on April 17, 2024, at 10:56 AM, Employee 1 indicated that the facility vendor had been out to the facility on a service call, and that he had adjusted the water temperature regulators and that the chemical sanitation solution was also adjusted so the dishes would be properly sanitized in the event the water temperatures were to drop again. The surveyor requested a copy of the service providers report.</p> <p>A follow-up observation of the Laurel Lane nourishment room refrigerator on April 17, 2024, at 10:37 AM, revealed the freezer still had slight food debris noted; that the refrigerator still had a red sticky substance on the shelving; a yellow colored sticky substance on the base of refrigerator; the insulated gasket molding at the bottom of the door was busted; food debris was still present in the recessed door handles and in the rubber insulated gasket molding; and the microwave had microwave with food splatter moderate amount.</p> <p>A follow-up observation of the Chapelwood nourishment room refrigerator on April 17, 2024, at 10:41 AM, revealed that the large, sticky, red residue in the refrigerator and the large brown, sticky spill on the floor in front of refrigerator remained.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 17, 2024, at 2:10 PM, the NHA indicated that she was aware of the food storage and cleanliness concerns that had been identified. The surveyor shared that there were concerns in the kitchen, in all nourishment room refrigerators, and in the ice machine on the Evergreen Way.</p> <p>A follow-up observation of the Evergreen Way ice machine on April 18, 2024, at 9:14 AM, revealed that the ice scoop was housed properly in the storage bin and the ice machine door had been cleaned.</p> <p>A follow-up observation of the Evergreen Way nourishment room refrigerator on April 18, 2024, at 9:15 AM, revealed that the red and yellow, dried, sticky appearing residue remained, as well as the heavy food splatter yellow in color in the microwave.</p> <p>Review of the work order dated April 16, 2024, revealed a service call was completed between 5:00 PM and 6:00 PM. The report indicated that they checked the temperature on the second cycle after they arrived to get an accurate reading. Wash was steady at 175 degrees Fahrenheit. Rinse cycle never made it up past 170 degrees Fahrenheit. Adjusted both booster temperature and wash tank thermostat. Ran a few cycles to get everything up to temp[erature]. Wash stays steady at 160 [degrees Fahrenheit] through cycle and rinse stays above 170 [degrees Fahrenheit] through cycle.</p> <p>During an interview with the NHA and DON on April 18, 2024, at 11:28 AM, the confirmed that she would expect food to be properly stored, labeled, dated, and discarded according to facility policy and guidelines.</p> <p>During a final email communication received from the NHA on April 18, 2024, at 1:46 PM, the NHA confirmed that she would expect dishwasher temperatures to be taken at each meal and recorded, that the dishwasher would meet required temperatures for sanitation of the dishes, and that unit refrigerators/microwaves/ice machines to be cleaned on a routine basis or when a spill occurs.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>(continued on next page)</p>		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	28 Pa. Code 201.18(b)(1) Management

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>37116</p> <p>Based on review of facility documents and staff interview, it was determined that the facility failed to ensure that all required staff persons were in attendance at quarterly Quality Assurance Process Improvement (QAPI) Committee meetings for one of four quarters reviewed (fourth quarter, October - December 2023).</p> <p>Findings include:</p> <p>A review of Quality Assurance/Performance Improvement (QAPI) Committee meeting sign-in sheets for the period of April 2023 through March 2024, failed to reveal that the Nursing Home Administrator (NHA), owner, board member, or other person in a leadership role was present at any of the meetings held in the fourth quarter of 2023.</p> <p>During an interview with the NHA on April 18, 2024, at 12:00 PM, she revealed that she was not able to locate any sign-in sheets that had all required members for that time period.</p> <p>28 Pa. Code S201.18(e)(1)(2)(3) Management</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37013</p> <p>Based on facility document review and staff interview, it was determined that the facility failed to maintain an accurate data collection system of infection surveillance from June 2023 through September 2023.</p> <p>Findings Include:</p> <p>Review of facility form, titled Monthly Infection Control Log (Line List), revealed data to be collected and documented each month include resident's name, room number, unit, type of infection, date of infection, culture, antibiotic resistant, classification, and isolation precautions.</p> <p>Review of the facility's completed Monthly Infection Control Log (Line List) failed to reveal that any documentation of infections occurred for June, July, August or September in 2023.</p> <p>On April 18, 2024, at 8:36 AM, the Nursing Home Administrator stated the facility was unable to locate any infection tracking for June, July, August or September in 2023.</p> <p>28 Pa. Code 201.14(a)(c) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa code 211.10(a) Resident care policies</p>

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>37116</p> <p>Based on personnel file review and staff interview, it was determined that the facility failed to ensure each nurse aide was provided required in-service training consisting of no less than 12 hours per year for five of five nurse aide employee records reviewed (Employees 5, 6, 7, 8, and 9).</p> <p>Findings Include:</p> <p>Review of select facility documentation revealed that Employee 5 was hired in 2015; Employee 6 was hired in 2022; Employee 7 was hired in 2018; Employee 8 was hired in 2009; and Employee 9 was hired in 2008.</p> <p>Review of training records provided by the facility failed to reveal evidence that Employees 5, 6, 7, 8, and 9 received at least 12 hours of annual in-service training.</p> <p>During an interview with the Nursing Home Administrator on April 18, 2024, at 11:59 AM, she acknowledged the concern with the aforementioned nurse aides not completing 12 hours of in-service training annually.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 201.20(a)(d) Staff development</p>		