

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395284	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Phoenix Center for Rehabilitation and Nursing,the		STREET ADDRESS, CITY, STATE, ZIP CODE 833 South Main Street Phoenixville, PA 19460	

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 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35913</p> <p>Based upon clinical record review and interview, it was determined the facility failed to ensure the formulation of Advance Directives was offered upon admission for one of 18 residents reviewed (Resident 223).</p> <p>Findings include:</p> <p>Review of Resident 223's clinical record revealed Resident 223 was admitted to the facility on [DATE].</p> <p>Further review of Resident 223's clinical record failed to reveal evidence of the formulation of Advance Directives and failed to reveal evidence of the offering of the formulation of Advance Directives to Resident 223's representative upon admission.</p> <p>Interview with the Nursing Home Administrator on August 22, 2024, at 10:30 a.m. confirmed no evidence that the formulation of an Advance Directive was offered to Resident 223's representative upon admission and further confirmed no Advance Directives existed for Resident 223.</p> <p>28 Pa. Code 211.5(f) Clinical Records</p> <p>Previously cited 9/22/2023, 3/20/2024</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>30934</p> <p>Based on facility policy and procedure review, clinical record review, and staff interview, it was determined the facility failed to notify the physician of a change in a resident condition for one of 24 residents reviewed. (Resident 173)</p> <p>Findings Include:</p> <p>Review of facility policy and procedure titled Change in a Residents Condition or Status, Revised December 2016, revealed Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medica;/mental condition and/or status. The nurse will notify the resident's Attending Physician or physician on call when there has been a(n): significant change in the resident's physical/emotional/mental condition.</p> <p>Review of Resident 173's progress notes reveled a nursing entry dated December 9, 2023 at 6:50 a.m. stating Resident was received in bed. Resident was observed with bright red bloody urine draining from his foley catheter (tube placed into the penis to drain urine from the bladder) and resident was also observed with bright red blood clots coming from his penis. There was no documented evidence the resident's physician was notified of this change in condition.</p> <p>Further review of Resident 173's progress notes revealed a nursing entry dated December 9, 2023 at 3:40 p. m. stating Resident lethargic and found with large clots coming from penis. Foley bag filled with bright red blood .new order received to send resident to ER (emergency room) for evaluation.</p> <p>Interview with the Nursing Home Administrator on August 22, 2024 at 10:30 a.m. confirmed Resident 173's physician was not notified of the change in condition when the resident was found to be bleeding from his penis on December 9, 2023 at 6:50 a.m. and was sent to the hospital later that day.</p> <p>28 Pa. Code 211.5(f) Clinical Records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p> <p>28 Pa Code: 211.10(c) Resident care policies</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35913</p> <p>Based upon review of facility policy and procedure, clinical records, and documentation provided by the facility and staff interviews, it was determined the facility failed to thoroughly investigate a fall causing possible injury for one of 18 residents reviewed (Resident 223).</p> <p>Findings include:</p> <p>Review of facility policy and procedure titled Residents Right to freedom from Abuse, Neglect and Exploitation Policy and Procedure revealed in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility shall: a) ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in the proper timeframe pursuant to this policy; b) have evidence that all alleged violations are thoroughly investigated; c) prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress; d) report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Review of Resident 223's clinical record revealed Resident 223 was admitted to the facility on [DATE], for respite care.</p> <p>Review of Resident 223's progress notes dated [DATE], revealed At 3:25 p.m. called in by charge nurse to assess resident post fall. Upon arrival to room, resident found on bed with CNA [nurse aide] at bedside. Resident alert to name, verbal, unable to provide details of fall. Resident had an unwitnessed fall. Resident started on neuro checks per facility policy. Resident denies pain, full body assessed, no injury noted. Resident placed on close observation due to fall. At 3:35 p.m. charge nurse reported resident is sweating profusely. VS [vital signs] abnormal. Charge nurse called [physician] on call services, received order to transfer resident to ER [emergency room] for further evaluation. 911 called, ambulance arrive at 3:40 p.m., at 3:42 p.m. resident stopped breathing, no respirations noted. Resident code status not available on file, per facility protocol, immediately CPR [cardio-pulmonary resuscitation] started by EMTs [emergency medical technicians]. Airway established. 4 more EMT's arrived. CPR continued for 15 minutes, resident then transferred to [acute facility] via ambulance. Family notified. DON [Director of Nursing] notified. MD [Medical Doctor] notified. DON called in to check on status, resident declared dead at the hospital. Belongings secured in room and family made aware of resident passing at hospital.</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>Review of documentation provided by facility dated [DATE], revealed On [DATE] at approximately 14:51, an aide was providing care to the resident who was in bed. The aide turned to pick up supplies and while she was turned, the resident started rolling. The aide tried to stop her but couldn't and the resident fell to the floor. The aide went to the nurses' station to get help. She returned to the room with 2 nurses. The first nurse went into the room with her, the other nurse turned around and got the equipment to take vital signs. The resident was assessed and had no apparent injury. Resident was verbal and responding. The nurse took the resident's vital signs and began 15-minute neurochecks. BP was high and pulse ox was low- nurse called physician service. The physician's service returned the call at approximately 15:15 and directed the nurse to send the resident out to hospital. The aide stayed with the resident throughout and reported that resident was responsive throughout. EMTs arrived at 15:25. While EMTs were in the room, the resident stopped breathing and CPR was initiated. EMTs placed resident on [NAME] devise. EMTs left with resident at 15:46. The Resident was transported to hospital where she was diagnosed with Cardiac Arrest. The husband agreed to stop CPR and the resident was pronounced dead at 16:01.</p> <p>Follow Up - Investigation occurred. Hospital records were obtained. Hospital did call coroner who decided death was not a coroner's case.</p> <p>Further review of facility documentation and Resident 223's clinical record failed to reveal evidence that Resident 223's fall was thoroughly investigated to determine the actual cause of the fall and potential injury and the resulting cardiac arrest and expiration of Resident 223.</p> <p>Interview with the Nursing Home Administrator on [DATE], at 10:00 a.m. confirmed a thorough investigation into Resident 223's fall and subsequent expiration was not conducted.</p> <p>28 Pa. Code 201.18(a)(b)(1)(2) Management</p> <p>Previously cited [DATE]</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30934</p> <p>Based on clinical record review, hospital record review, and staff interview it was determined the facility failed to provide care and services related to monitoring a residents health status and following recommendations after transfer from an acute care hospital for one of 24 residents reviewed. (Resident 173)</p> <p>Findings Include:</p> <p>Review of facility policy and procedure titled Acute Condition Changes- Clinical Protocol, last revised December 2015 revealed before contacting a physician about someone with an acute change in condition, the nursing staff will make detailed observations and collect pertinent information to report to the physician . nurses are encouraged to use the communication form and progress note as a tool to help gather and organize information before notifying the physician.</p> <p>Review of Resident 173's progress notes revealed a nursing entry dated August 10, 2024 at 2:31 p.m. stating Went to flush resident catheter for 7-3 shift foley bag (bag used to contain urine from tube that is placed through the penis into the bladder to drain urine) contained blood and around the penis was bloody, attempted to flush foley which was not patent (open), I then notified the supervisor. The on call MD was called and ordered resident to be sent out to the emergency room .</p> <p>Further review of Resident 173's clinical record revealed there was no documented vital signs during this incident when the resident was sent out to the hospital, or a full assessment completed and no documentation on the resident's status since a progress note on August 1, 2024 at 12:23 p.m.</p> <p>Review of Resident 173's documentation from the hospital when sent to theER on [DATE] revealed when Resident 173 entered the emergency room , they had a temperature of 103.8 (normal 98.6), a blood pressure of 115/42 (normal 120/80) and a pulse ox (measure of amount of oxygen in the blood stream) of 89% (normal above 90). The resident was also noted to have thick dark urine in [resident] foley catheter and sick looking and looked dehydrated.</p> <p>Interview with the Nursing Home Administrator revealed there was no documented evidence of a full assessment or adequate monitoring completed for Resident 173 with the change of condition on August 10, 2024.</p> <p>Review of Resident 173's Progress Notes revealed a nursing entry dated November 16, 2023 at 8:30 a.m. stating the resident had been admitted to the hospital with no diagnosis as of yet.</p> <p>Review of Resident 173's discharge instructions when they were discharged from the hospital on November 21, 2023 revealed a recommendation to follow up with urology in two weeks.</p> <p>Review of Resident 173's Progress Notes revealed a nursing entry dated January 24, 2024 at 8:52 p.m. stating the resident was admitted to the hospital with a diagnosis of possible UTI (Urinary Tract Infection) due to cloudy urine and elevation WBCs (White Blood Cells- elevated level is indicative of infection).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 173's discharge instruction when they were discharged from the hospital on January 27, 2024 revealed a recommendation to follow up with urology in two weeks.</p> <p>Interview with the Nursing Home Administrator on August 22, 2024 at 10:30 a.m. confirmed the resident has not been scheduled for a follow-up with urology as recommended after the hospitalization of December 10, 2023 and January 24, 2024.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30934</p> <p>Based on observation, clinical record review and staff interview it was determined the facility failed to provide care and services for a resident with a foley catheter for one of two residents reviewed. (Resident 54)</p> <p>Findings Include:</p> <p>Observation of Resident 54 on August 19, 2024 at 9:30 a.m. revealed the resident had a Foley catheter (Tube placed into the bladder to drain urine).</p> <p>Review of Resident 54 clinical record revealed the resident was admitted to the facility on [DATE] with a Foley catheter.</p> <p>Further review of Resident 54's clinical record revealed there was no assessment to determine the need of the foley catheter and the catheter was not removed to attempt a voiding trial after admission.</p> <p>Review of Resident 54's progress notes revealed a nursing entry dated August 21, 2024 at 4:11 p.m. stating Resident 54's spouse and an RN from an outside agency requested for the resident to have a voiding trial for the patient. The medical doctor was called and gave an order for a voiding trial that was successful.</p> <p>Interview with the Nursing Home Administrator on August 22, 2023 at 10:30 a.m. confirmed the facility did not assess the need for the foley catheter upon admission or attempt a voiding trial for Resident 54 until it was requested on August 21, 2024.</p> <p>28 Pa. Code 211.5 (f) Clinical record</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3) Nursing services</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>30934</p> <p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on facility policy review, clinical record review, and staff interview it was determined the facility failed to monitor the nutritional status for three of seven residents reviewed. (Residents 4, 15, and 66)</p> <p>Findings Include:</p> <p>Review of facility policy Weight Assessment and Intervention updated January 10, 2023, revealed weights will be recorded in each unit's Weight Record chart or notebook and then entered in the individual's medical record by the facility's designated weight manager. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation.</p> <p>Review of Resident 4's weights revealed a weight on July 18, 2024, of 154.4 pounds and a weight on August 1, 2024 of 170.2 (gain of 15.8 pounds or 9.3%). Review of Resident 4's weight change note of August 2, 2024, revealed that the registered dietitian requested a re-weight to validate the weight.</p> <p>Further review of Resident 4's clinical record revealed that a reweight was not obtained until August 20, 2024 (18 days later).</p> <p>Interview with Employee E3 confirmed that the reweight was not obtained in a timely manner.</p> <p>Review of Resident 15's weights revealed a weight on July 31, 2024, of 242 pounds, and a weight on August 8, 2024, of 210 pounds. A loss of 32 pound or 13.22%.</p> <p>Review of Resident 15's progress notes revealed a weight alert note on August 8, 2024, from the registered dietitian requesting a re-weight.</p> <p>Further review of Resident 15's weights revealed there was no re-weight completed as requested and the next weight in the resident's clinical record is on August 20, 2024, of 215 pounds indicating the weight of July 31, 2024, was inaccurate.</p> <p>Review of Resident 15's hospital dietary notes dated July 12, 2024, revealed the resident weighed 226 pounds on June 19, 2024, and 226 pounds on July 11, 2024.</p> <p>Further review of Resident 15's clinical record revealed a weight from June 19, 2024, of 227 pounds that was marked out and labeled as incorrect documentation.</p> <p>Interview with the Employee E3 on August 22, 2024, at 11:44 a.m. confirmed Resident 15's weight loss identified on July 31, 2024, was not addressed until August 20, 2024. Employee E3 stated the weight from June 19, 2024, of 227 pounds was probably the resident's correct weight. Employee E3 stated the resident had cellulitis and edema since April. Employee E3 also stated the resident is prescribed Ozempic and Lispro for diabetes, all of which could be factors in significant weight changes.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 66's weights revealed a weight on April 10, 2024 of 66.4 pounds, and a weight on May 17, 2024 of 59.1 pounds. A loss of 7.3 pound or 11%.</p> <p>Review of Resident 66's progress notes revealed a weight alert note on May 17, 2024 from the registered dietitian requesting a re-weight.</p> <p>Further review of Resident 66's weights revealed there was no re-weight completed as requested and the next weight in the resident's clinical record is on June 4, 2024 of 59.8 pounds indicating the weight of May 17, 2024 was accurate.</p> <p>The weight of June 4, 2024 was addressed on June 10, 2024 with a new intervention to give the resident a magic cup (fortified nutrition dessert cup) three times a day. Review of Resident 66's physician orders revealed the resident was ordered Magic cup three times a day on June 6, 2024.</p> <p>Interview with the Nursing Home Administrator on August 22, 2024 at 10:30 a.m. confirmed Resident 66's weight loss identified on May 17, 2024 was not addressed until June 6, 2024.</p> <p>28 Pa. Code 211.5(f) Clinical Records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p> <p>28 Pa Code: 211.10(c) Resident care policies</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>35913</p> <p>Based upon observation and clinical record review, it was determined the facility failed to ensure tube feedings were delivered according to physician orders for one of three residents observed (Resident 16).</p> <p>Findings include:</p> <p>Review of Resident 16's physician orders revealed an order dated May 22, 2024, for Enteral Feed every shift for nutrition; Formula Jevity 1.5 via pump at the rate of 55 ml/hr [55 milliliters per hour] x 24 hours.</p> <p>Observation on August 19, 2024, at 12:04 p.m. revealed Resident 16's enteral feed pump turned off. Further observation revealed a new bottle of Jevity 1.5 that was documented to have been placed on August 19, 2024 at 10:30 a.m. The bottle contained 1000 ml of tube feeding.</p> <p>Observation on August 20, 2024, at 10:15 a.m. revealed the same enteral feed bottle hanging with 300 ml left in the container and the pump was then running at 55 ml/hour.</p> <p>Review of Resident 16's clinical record failed to reveal evidence as to why Resident 16's tube feeding pump was turned off and/or not functioning and failed to reveal any documentation as to how much tube feeding was not provided due to the tube feeding pump not running.</p> <p>The facility failed to ensure that Resident 16's tube feeding for nutrition was running continuously at 55 ml/hour as ordered by the physician.</p> <p>The above information was conveyed to the Nursing Home Administrator on August 22, 2024, at 10:00 a.m.</p> <p>28 Pa. Code 211.12(c)(d)(1)(2)(5) Nursing Services</p> <p>Previously cited 9/22/2023, 3/20/2024</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35913</p> <p>Based upon review of facility policy and procedure, observation, and clinical record review, it was determined the facility failed to establish Enhanced Barrier Precautions for four of four residents observed (Resident 16, Resident 54, Resident 58, and Resident 173).</p> <p>Findings include:</p> <p>Review of facility policy and procedure titled Enhanced Barrier Precaution (EBP) Policy and Procedure revealed It is the policy of the facility to follow state and federal guidelines to minimize the spread of Multidrug Resistant Organisms (MDROs) by implementing effective Personal Protective Equipment (PPE) usage. Enhanced Barrier Precautions [EBP] are to be utilized for all residents with any of the following: infection or colonization with an MDRO when contact precautions do not apply; wounds and/or indwelling medical devices (e.g. central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status.</p> <p>Review of Resident 16's clinical record revealed Resident 16 has a PEG (feeding tube) in place.</p> <p>Observation of Resident 16's room failed to reveal evidence of PPE or EBP signage.</p> <p>Review of Resident 54's clinical record revealed Resident 54 was admitted to the facility on [DATE], with a foley (urinary) catheter in place.</p> <p>Observation of Resident 54's room failed to reveal evidence of PPE or EBP signage.</p> <p>Review of Resident 58's clinical record revealed Resident 58 was admitted to the facility on [DATE], with a foley catheter in place.</p> <p>Observation of Resident 58's room failed to reveal evidence of PPE or EBP signage.</p> <p>Review of Resident 173's clinical record revealed Resident 173 was readmitted to the facility on [DATE], with a foley catheter and peripherally inserted central catheter (PICC) line in place for antibiotic usage.</p> <p>Observation of Resident 173's room failed to reveal evidence of PPE or EBP signage.</p> <p>Interview with the Nursing Home Administrator on August 22, 2024, at 11:00 a.m. confirmed no Enhanced Barrier Precautions were in place throughout the building.</p> <p>28 Pa. Code 201.18(a)(b)(1)(2)(3) Management</p> <p>Previously cited 9/22/2023</p> <p>28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing Services</p> <p>Previously cited 9/22/2023, 3/20/2024</p>		