

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/20/2025
NAME OF PROVIDER OR SUPPLIER  Pleasant Acres Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  118 Pleasant Acres Rd,rd7 York, PA 17402	

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 - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>37116</p> <p>Based on review of facility policy, clinical record review, observations, and interviews with staff and residents, it was determined that the facility failed to ensure that care and services were provided in a manner that enhanced resident dignity for five of 41 residents reviewed (Residents 75, 150, 180, 195, and 310).</p> <p>Findings include:</p> <p>Review of the facility policy, titled Dignity and Respect with a last reviewed and revised date of April 2024, revealed, Residents shall be treated with dignity and respect at all times. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p> <p>Review of Resident 75's clinical record revealed diagnoses that included Alzheimer's disease with early onset and secondary parkinsonism (different conditions that can cause movement symptoms similar to those associated with Parkinson's disease including tremor, slowed movements, and stiffness).</p> <p>Observation of Resident 75 on March 18, 2025, at 1:01 PM, revealed her independently ambulating around the nursing unit. Resident 75 was observed wearing a shirt made of thin fabric with no bra, which exposed her breasts underneath.</p> <p>During an immediate interview with Employee 14 (Nurse Aide) she revealed that Resident 75 does wear bras, and took Resident 75 back to her room to put one on.</p> <p>A follow-up observation of Resident 75, at 1:34 PM, revealed she was wearing the same shirt, with a bra, making her breasts no longer visible through her shirt.</p> <p>Review of Resident 75's upper body dressing task documentation for that morning revealed that it was documented at 10:00 AM that she was fully dependent on staff for that activity.</p> <p>Review of Resident 75's care plan failed to reveal a preference for not wearing undergarments.</p> <p>During an interview with the Director of Nursing (DON) on March 20, 2025, at 10:13 AM, she stated that another staff member had just noticed the concern with Resident 75 and was planning to address it when Employee 14 took Resident 75 to her room to redress her.</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 - Some</p>	<p>Observation of Resident 150 on March 17, 2025, at 10:01 AM, revealed Resident 150 lying in bed. Employee 10 (Housekeeper) entered the room to sweep the floor while talking on her cell phone, via an in-ear device. Resident 150 attempted to ask Employee 10 if she was going to sweep the bathroom also, to which Employee 10 motioned for Resident 150 to stop talking and then told Resident 150, I'm on the phone with my grandma.</p> <p>An interview with Resident 195 on March 17, 2025, at 10:34 AM, revealed that staff members often answer his call bell while talking on the phone via an in-ear device and he finds it very disrespectful.</p> <p>An interview with Nursing Home Administrator on March 18, 2025, at 1:15 PM, revealed that he would expect staff members to treat residents with dignity and respect.</p> <p>Review of Resident 180's clinical record revealed diagnoses that included dementia with behavioral disturbance (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life) and unspecified psychosis (abnormal condition of the mind that involves a loss of contact with reality).</p> <p>Review of Resident 310's clinical record revealed diagnoses that included Alzheimer's disease (gradually progressive brain disorder that causes problems with memory, thinking and behavior) and anxiety disorder (mental disorder characterized by feelings of worry about future events and/or fear in reaction to current events).</p> <p>Observation on March 17, 2025, at approximately 12:10 PM, revealed Residents 180 and 310 sitting in the dementia care unit dining room during meal service; other residents were present and eating their meals. Employee 13 (Physician) approached Residents 180 and 310, placed his stethoscope on their chests, and asked them questions about their health status. Employee 13 was not observed asking Resident 180 or 310 for permission to examine them in a common area with other residents present.</p> <p>During an interview with the DON on March 20, 2025, at 10:13 AM, she revealed the expectation that residents would be provided privacy during examinations.</p> <p>28 Pa. Code 201.18(b)(2)(e)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</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>37116</p> <p>Based on observations and staff interviews, it was determined that the facility failed to maintain a safe, clean, comfortable, and home-like interior on two of five nursing units (Main 1 and fifth floor nursing units).</p> <p>Findings include:</p> <p>Observation in Resident 338's room on March 17, 2025, at 10:47 AM, revealed the black plastic fan on nightstand contained a dark grey fuzzy substance.</p> <p>Observation on March 20, 2025, at 10:31 AM, revealed the dark grey substance remained on the black plastic fan on the nightstand.</p> <p>During an interview with Employee 11 (Nurse Aide) on March 20, 2025, at 10:50 AM, it was revealed that she was aware of the dirty fan in Resident 338's room. It was also revealed that she told Employee 12 (Housekeeper) about it two days ago and requested that it be cleaned.</p> <p>Employee 12 was on the unit and Employee 11 asked her to clean Resident 338's. Employee 12 responded that she wasn't allowed to clean the fan. At 11:05 AM, Employee 12 was observed with Resident 338's fan entering the housekeeping closet.</p> <p>During an interview with Employee 1 (Assistant Nursing Home Administrator) it was revealed that housekeeping should've cleaned the fan when it was observed to be dirty.</p> <p>Observation on March 17, 2025, at 9:39 AM, in the Main 1 (locked dementia care unit) TV lounge revealed multiple chairs with dried liquid spills and other debris on the cushions and/or frames. Additionally, approximately three chairs were observed to have cracked or ripped cushions.</p> <p>Observations on March 17, 2025, at 9:53 AM; on March 18, 2025, at 9:41 AM; and on March 19, 2025, at 12:45 PM, in Resident 178's room revealed a medical pump and pole. The feet of the pole were covered in a dried liquid substance.</p> <p>Review of Resident 178's Medication Administration Record (MAR - form used to document physician orders as well as when and how medications are administered to a resident) revealed orders for intravenous hydration, which ended on March 14, 2025.</p> <p>Observations on March 17, 2025, at 10:00 AM, and on March 19, 2025, at 9:47 AM, in the Main 1 dining room revealed several chairs with dried liquid spills and other debris on the cushions and/or frames.</p> <p>Observation on March 17, 2025, at 12:14 PM, and on March 19, 2025, at 12:46 PM, revealed Resident 178's wheelchair had an accumulation of dried food and debris on the seat and arm rests.</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>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37116</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 three of 41 residents reviewed (Residents 21, 259, and 351).</p> <p>Findings Include:</p> <p>Review of Resident 21's clinical record revealed diagnoses that include anoxic brain damage (occurs when the brain is completely deprived of oxygen, leading to brain cell death and potential long-term impairments) and gastro-esophageal reflux disease (a chronic condition where stomach contents flow back up into the esophagus, causing irritation and various symptoms).</p> <p>Review of Resident 21's Significant change MDS (Minimum Data Set is part of federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated December 19, 2024, revealed in Section O0110. Special Treatments, Procedures, and Programs, that Resident 21 has not been treated for in the previous 14 days while a resident.</p> <p>Review of Resident 21's physician's orders revealed an order from December 11, 2024, to admit Resident 21 to hospice services.</p> <p>Review of Resident 21's care plan revealed a care plan with a date initiated of December 12, 2024, with a focus area of, I have been admitted to hospice related to end stage disease process.</p> <p>Interview with the Nursing Home Administrator (NHA) on March 20, 2025, at 8:58 AM, revealed that Resident 21's MDS completed on December 19, 2024, was marked in error and that Resident 21 had been receiving hospice services at that time.</p> <p>Review of Resident 259's clinical record revealed diagnoses that included dementia with behavioral disturbance (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life) and major depressive disorder (mental disorder characterized by at least two weeks of low mood that is present across most situations).</p> <p>Further review of Resident 259's clinical record revealed that, in response to a pharmacy recommendation, the physician documented on September 25, 2024, that a gradual dose reduction of her Seroquel (antipsychotic) medication was contraindicated because the benefits outweighed the risks.</p> <p>Review of Resident 259's December 5, 2024, quarterly MDS revealed that it was coded to indicate that the physician had not documented that a gradual dose reduction of her antipsychotic medication was contraindicated.</p> <p>During an interview with Employee 15 (Registered Nurse Assessment Coordinator) on March 20, 2025, at 9:36 AM, she confirmed that Resident 259's assessment should have captured the date that the physician documented that a gradual dose reduction of the antipsychotic was contraindicated.</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 Assistant NHA on March 20, 2025, at 10:11 AM, she confirmed that she was aware that Resident 259's MDS was coded in error.</p> <p>Review of Resident 351's clinical record revealed diagnoses that included dementia and cirrhosis of liver (a chronic liver disease characterized by the replacement of healthy liver tissue with scar tissue, which can lead to liver failure and other complications).</p> <p>Review of Resident 351's clinical record revealed a progress note dated December 20, 2024, at 3:16 PM, indicating Resident 351 left AMA (against medical advice) with her daughter and returned to her home in the community.</p> <p>Review of Resident 351's discharge MDS dated [DATE], revealed that Section A2105. Discharge Status was marked that Resident 351 was discharged to a short-term general hospital (acute hospital).</p> <p>During an interview with the NHA on March 20, 2025, confirmed that Resident 351 did leave the facility AMA and returned home, and revealed the discharge MDS dated [DATE], was marked inaccurately and should have reflected that Resident 351 was discharged to home instead, and that a modification has been made.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing Services</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34631</p> <p>Based on clinical record review, observation, and resident and staff interviews, it was determined that the facility failed to develop a comprehensive person-centered care plan for four of 41 records reviewed (Residents 144, 161, 221, and 265).</p> <p>Findings include:</p> <p>A review of Resident 144's clinical record revealed diagnoses that included dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) and anxiety disorder (a group of mental health conditions characterized by excessive and persistent fear or worry, significantly impacting daily life and functioning).</p> <p>A review of Resident 144's care plan dated March 2025 failed to reveal a care plan for the diagnosis of dementia.</p> <p>During an interview with the Director of Nursing (DON) on March 19, 2025, the DON thought that his care plan for traumatic brain injury and cerebrovascular accident was adequate.</p> <p>A dementia care plan for Resident 144 was developed on March 19, 2025, and presented to the surveyor.</p> <p>Review of Resident 161's clinical record revealed diagnoses that included cerebral vascular accident (aka stroke- damage to the brain from interruption of its blood supply) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).</p> <p>Observation of Resident 161 on March 18, 2025, revealed the presence of bilateral enabler bars attached to his bed.</p> <p>Review of Resident 161's current physicians orders and care plan failed to reveal the Resident had enabler bars.</p> <p>Further review revealed the physician orders and care plan were not updated to include the enabler bars after the Resident returned from the hospital on October 26, 2024. The Director of Nursing (DON) was able to show that maintenance has been documenting safety checks on the enabler bars.</p> <p>During an interview with the DON on March 19, 2025, at 9:30 AM, the DON was able to reveal that Resident 161 was assessed and ordered enabler bars prior to his hospitalization on [DATE], and agreed that the current care plan and physician orders should reflect enabler bars are being utilized by Resident 161.</p> <p>A review of Resident 221's clinical record revealed diagnoses that included heart failure (sometimes called congestive heart failure, which means the heart can't pump enough blood to meet the body's needs, often due to a weakened or stiff heart muscle) and a history of falls.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation in Resident 221's room on March 17, 2025, at 11:01 AM, revealed enabler bars attached to both sides of the bed.</p> <p>Review of Resident 221's interdisciplinary plan of care revealed none developed regarding the use of the bilateral enabler bars.</p> <p>An interview with the DON on March 19, 2025, at 12:54 PM, revealed an enabler bars care plan has now been developed and added to Resident 221's interdisciplinary plan of care.</p> <p>A review of Resident 265's clinical record revealed diagnoses that included impaired visual function.</p> <p>An observation and interview with Resident 265 on March 17, 2025, at 11:55 AM, revealed her eyes to appear bloody and red. The interview revealed she received eye injections for macular edema (a condition where fluid accumulates in the macula, the central part of the retina responsible for sharp, central vision).</p> <p>Review of Resident 265's interdisciplinary plan of care revealed none developed to address any visual function, diagnoses, or treatment by the ophthalmologist.</p> <p>An interview with the Assistant Nursing Home Administrator on March 19, 2025, at 10:32 AM, confirmed a vision care plan has now been developed and added to Resident 265's interdisciplinary plan of care.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>33305</p> <p>Based on observations, clinical record review, and staff interviews, it was determined that the facility failed to review and revise the resident's care plan to reflect the resident's current status for two of 41 residents reviewed (Residents 161 and 327).</p> <p>Findings include:</p> <p>Review of Resident 161's clinical record revealed diagnoses that included cerebral vascular accident and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).</p> <p>Review of Resident 161's POLST (Pennsylvania orders for Life-Sustaining Treatment) and advance directive (a form to make health care decisions for the individual if the individual loses the capacity to make health care decision) on March 19, 2025, revealed the Resident desired his code status be do not resuscitate (DNR).</p> <p>Review of Resident 161's March 2025 physician orders revealed the Resident desired his code status DNR.</p> <p>A review of Resident 161's care plan dated March 2025 stated, wants to be full code. With a created date of September 30, 2024.</p> <p>A review of the progress notes revealed that code status was clarified to be DNR status on October 3, 2024, but the care plan was never corrected.</p> <p>Interview with the DON on March 19, 2025, at 10:30 AM, revealed the care plan should have matched Resident 161's physician orders, POLST and advance directive code status.</p> <p>Review of Resident 327's clinical record revealed diagnoses that included presence of a cardiac implant and atrial septal defect (abnormal hole in the wall between the two upper chambers of the heart).</p> <p>Review of Resident 327's physicians orders revealed an order to ensure each shift that the loop recorder monitor (small device implanted under the skin of the chest to continuously monitor and record the heart's electrical activity) was attached to the nightstand and was plugged in starting February 21, 2025. Review also revealed an order for quarterly remote loop recorder monitoring, starting February 21, 2025.</p> <p>Observation on March 18, 2025, at 12:40 PM, revealed that the loop recorder monitor was present on Resident 327's nightstand.</p> <p>Review of Resident 327's current care plan failed to reveal any information regarding the presence or care of his loop recorder implant.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>33305</p> <p>Based on staff interviews, record review, and the facility's licensed staff scope of practice, it was determined that the facility failed to follow professional standards of practice when transcribing orders and administering medications to one of 41 residents reviewed (Resident 144).</p> <p>Findings include:</p> <p>Review of the Pennsylvania Nursing Practice Act for Licensed Practical Nurses (LPN), Chapter 21.145. revealed Functions of the LPN. (a) The LPN is prepared to function as a member of the health-care team by exercising sound nursing judgement based on preparation, knowledge, experience in nursing and competency. The LPN participates in the planning, implementation and evaluation of nursing care using focused assessment in settings where nursing takes place. (1) An LPN shall communicate with a licensed professional nurse and patient's healthcare team members to seek guidance when the patient's care needs exceed the licensed practical nursing scope of practice.</p> <p>Review of the clinical record for Resident 144 revealed diagnoses that included dysphagia following nontraumatic subarachnoid hemorrhage (bleeding into the subarachnoid space of the brain) and gastrostomy tube status (a surgically created opening in the stomach through which a tube can be inserted for feeding and administering medications).</p> <p>Review of Resident 144's physician orders dated March 2025 NPO (Nothing by Mouth) diet, NPO texture, NPO consistency, effective September 26, 2024.</p> <p>On October 18, 2024, a physician order was written to allow patient to have ~6 ice cubes x3 daily w/ staff/family supervision for pleasure every 24 hours as needed.</p> <p>During an interview on March 19, 2025, with Employee 18 (Speech-Language-Therapist), Employee 18 revealed that Resident 144 was evaluated and approved for ice chips to decrease atrophy of his swallowing mechanism and confirmed that all nutrition and medications are administered via his gastrostomy tube.</p> <p>Review of Resident 144's physician orders revealed several medications had a route ordered to administer PO (per os) indicating to administer by mouth, that included;</p> <p>Acetaminophen Tablet 325 MG</p> <p>Give 2 tablet by mouth every 6 hours as needed for Elevated Temperature Give 2 tablets (650 mg) by mouth every 6 hours as needed for elevated temperature &gt;100.5 *Do not exceed 3 gms acetaminophen in 24 hours*</p> <p>Pharmacy Active 12/18/2024 03:31</p> <p>Quetiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate)</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give 1 tablet by mouth two times a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE 3/20/25 10:42 AM</p> <p>Lorazepam 0.5 mg 1 tablet PO two times a day effective 10/27/2024</p> <p>Further review of the MAR (medication administration record) revealed that the orders were transcribed PO and staff were signing off as administered PO.</p> <p>During an interview on March 19, 2025, with Employee 19 (Licensed practical Nurse), Employee 19 informed the surveyor she was fully aware that Resident 144 had a gastrostomy tube, and that all medications are administered via the gastrostomy tube.</p> <p>During an interview with the Director of Nursing (DON) on March 20, 2025, at 10:30 AM, the DON informed the surveyor that all medication nurses provided statements that they are aware of the gastrostomy status for Resident 144 and administer all medications via the gastrostomy tube. The DON confirmed that the orders should have stipulated the gastrostomy route for administrations, and that staff should have contacted the physician to correct the ordered route of administration on the orders.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/20/2025
NAME OF PROVIDER OR SUPPLIER  Pleasant Acres Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  118 Pleasant Acres Rd,rd7 York, PA 17402	

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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>37116</p> <p>Based on observation, 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 41 residents reviewed (Resident 120).</p> <p>Findings include:</p> <p>Review of Resident 120'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) and muscle weakness.</p> <p>Review of Resident 120's care plan revealed that she was a self care deficit and required assistance with most activities of daily living. Further review revealed that she removes her footwear and walks barefoot.</p> <p>Observation of Resident 120 on March 18, 2025, at 9:42 AM, revealed her asleep in bed. Her feet were exposed, and she was barefoot. A significant accumulation of dark black soiling was present on the soles of her feet. Observation of the floor in Resident 120's room revealed it felt dusty/gritty and had a dark buildup around the edges of the walls and furniture.</p> <p>During an immediate interview with Employee 16 (Nurse Aide) she confirmed that Resident 120 liked to go barefoot and, therefore, should have her feet washed daily.</p> <p>During an interview with the Director of Nursing on March 20, 2025, at 10:23 AM, she confirmed that Resident 120 does like to disrobe, independently ambulates, and staff wash her feet as needed.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>37817</p> <p>Based on facility policy, review of the clinical records, and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with physician orders for three of 41 residents reviewed (Residents 121, 221, and 338).</p> <p>Findings include:</p> <p>Review of facility policy, Medication Administration/Disposition, last revised September 6, 2023, read, in part, medications shall be administered in a safe and timely manner, and as prescribed by the physician. Medications must be administered within one hour of their prescribed time. The individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method or rout of administration before giving the medication. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and use the corresponding code on the Medication Administration Record (MAR - an electronic record of medication administration) to indicate the medication was not given and the reason for not administering. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones.</p> <p>Review of Resident 121's clinical record documented diagnoses that included bipolar (a mental health condition alternating periods of elation and depression), schizoaffective disorder (mental disorder involving a breakdown in the relation between thought, emotion, and behavior leading to faulty perception, inappropriate actions and feelings, affects a person's ability to think, feel, and behave clearly), cognitive communication deficit (difficulties in communication stemming from impairments in cognitive process), diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), and hypothyroidism (the thyroid gland doesn't produce enough thyroid hormone).</p> <p>Review of Resident 121's January 2025 MAR revealed there was no documentation (the MAR was blank) for the following medications:</p> <p>Lantus (insulin glargine - long acting insulin used to treat elevated blood sugar) inject 15 units subcutaneously (under the skin), with a start date of November 15, 2024, at 6:30 AM;</p> <p>Lantus inject 46 units, with a start date of January 11, 2024, at 8:30 PM;</p> <p>Levothyroxine Sodium (medication use to treat hypothyroidism) 75 micrograms, with a start date of January 11, 2023, at 6:30 AM;</p> <p>Melatonin 3 milligrams for sleeplessness, with a start date November 27, 2023, at 8:30 PM;</p> <p>Acetaminophen Oral Tablet 325 milligrams give 2 tablets three times a day for pain, with a start date of July 19, 2023, at 8:30 PM; and</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>Blood Sugar monitoring before meals and at bedtime, with a start date of January 10, 2023, not documented as completed at 6:30 AM and 8:30 PM.</p> <p>Review of Resident 121's progress note failed to document whether or not the aforementioned medications and blood sugar monitoring were administered/completed or rational for not following physician orders.</p> <p>A review of the facility's policy, titled Catheter-Foley, recently revised May 2024, read, in part, This policy provides the procedure to ensure the safe, sterile placement and removal of the Foley catheter. It also provides guidelines for catheter care and specimen collection from the catheter.</p> <p>A Foley Catheter is a device that drains urine from the urinary bladder into a collection bag outside of the body when you can't void the urine on your own.</p> <p>A review of Resident 221's physician orders revealed diagnoses that included hypertension (elevated blood pressure) and neuromuscular dysfunction of the bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain don't work the way they should. Common symptoms include dribbling urine, loss of feeling that the bladder is full, and being unable to control urine [urinary incontinence]).</p> <p>A review of Resident 221's Treatment Administration Record (TAR) dated January 2025, revealed the following physician's order Empty Foley drainage bag every shift and record output, every shift.</p> <p>A review of the TAR revealed the staff had not documented care to the Foley on the evening shift of January 5, 2025; the day and night shifts on January 9, 2025; the day shift on January 14, 2025; and the evening shift on January 31, 2025.</p> <p>A review of Resident 221's February 2025 TAR revealed the staff had not documented the Foley catheter care during the evening shift on February 1, 2025; the day shift on February 5, 2025; and the evening shifts on February 14, 15 and 16, 2025.</p> <p>Continued review of Resident 221's February 2025 TAR revealed the following physician's order Irrigate Foley catheter with 60 mls [milliliters] of Sterile Normal Saline solution every shift for patency (the condition of being open, expanded, or unobstructed).</p> <p>A review of the TAR revealed staff had not documented the irrigation of the Foley during the evening shift on February 1, 2025; the day shift of February 5, 2025; and the evening shifts on February 14 and 15, 2025.</p> <p>An interview with the Director of Nursing (DON), on March 20, 2025, at 10:05 AM, revealed an agreement that staff should be documenting the care to Resident 221's catheter per physician orders.</p> <p>Review of Resident 338's clinical record documented diagnoses that included diabetes mellitus, spinal stenosis (narrowing of the spinal column that causes pressure on the spinal cord), and hemiplegia left non-dominant side (paralysis or weakness on one side of the body).</p> <p>Review of Resident 338's January 2025 MAR failed to document the following medication were administered on the following dates:</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>Atorvastatin Calcium (medication used to treat elevated cholesterol levels) 40 milligrams, with a start date of November 5, 2024, at 8:30 PM;</p> <p>Melatonin Oral Tablet 3 milligrams give 3 tablets for insomnia, with a start date of November 5, 2024, at 8:30 PM;</p> <p>Ativan 0.5 milligrams every 12 hours for anxiety, with a start date of November 20, 2024, at 8:30 PM;</p> <p>Baclofen Oral Tablet 10 milligram every 8 hours for spasms, with a start date of November 8, 2024, at 6:00 AM and 10:00 PM; and</p> <p>Insulin Lispro (fast acting insulin used to treat elevated blood sugar) Subcutaneous Solution Pen injector Inject as per sliding scale: if 0 - 150 milliliter/deciliter (ml/dl- unit of measure) = 0 units; 151 - 200 ml/dl = 2 units; 201 - 250 ml/dl = 4 units; 251 - 300 ml/dl = 6 units; 301 - 350 ml/dl = 8 units; 351 - 400 ml/dl = 10 units, before meals and at bedtime, with a start date of November 5, 2024, at 8:30 PM on January 19th and 24th.</p> <p>Review of Resident 338's progress note failed to document whether or not the aforementioned medications were administered or rational for not following physician orders.</p> <p>During an interview with the DON on March 20, 2025, at 10:09 AM, it was revealed that the MAR should be completed at time of administration or at time of resident refusal.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(a)(c) Resident care policies</p> <p>28 Pa. Code 211.12 (d) (5) Nursing services</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>37817</p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to maintain complete and accurate records related to dialysis communication for one of two residents reviewed who received dialysis services (Resident 96).</p> <p>Findings Include:</p> <p>Review of facility policy, Dialysis Management, last revised March 28, 2024, read, in part, interchange of information necessary for the care of the resident, communication form is placed in the binder after completion of the pre dialysis assessment and sent to dialysis with the resident; dialysis center personnel to complete Dialysis communication form and return to facility; upon return the facility is to review information provided on the communication form and address as priorate; facility is to complete post-dialysis information/data and place in resident's medical record; and obtain resident's dry weigh from dialysis center, post treatment documentation.</p> <p>Review of Resident 96's clinical record documented diagnoses that included congestive heart failure (the heart doesn't pump blood as it should), diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), chronic kidney disease stage 5 (kidneys are severely damaged and unable to filter waste and fluid from the blood), bipolar disorder (a mental health condition alternating periods of elation and depression).</p> <p>Review of Resident 96 March 2025, physician orders included: Dialysis Monday, Wednesday, and Friday, chair time at 10:30 AM, with a start date of September 12, 2024; record post-dialysis dry weight (weight after resident dialyzed - without excess fluid) on weight tab upon return from dialysis- use dialysis scale weekly every evening shift every Monday, with a start date of November 4, 2024.</p> <p>Review of Resident 96's weight history and January 2025 Medication Administration Record (documentation of medication or services per physician orders) failed to document dry weight per physician orders, Monday evening shift on January 6th, 20th, and 27th, 2025.</p> <p>Review of Resident 96's dialysis communication sheets revealed none were not completed for following dates in January 2025: 1st, 3rd, 8th, 10th, 13th, 15th, 17th, 20th, 22nd, 24th, 27th, 29th, and 31st.</p> <p>Review of Resident 96's dialysis communication sheets revealed none were not completed for following dates in March 2025: 12th and 14th.</p> <p>During an interview with the Director of Nursing (DON) on March 20, 2025, at 10:09 AM, it was revealed that the dialysis communication sheets should be completed, that the dialysis center has a history of not completing the post dialysis vital sign section, and that the facility had contacted the center to discuss the importance of completing the communication forms.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON on March 20, 2025, at 11:51 AM, it was revealed the dry weight should've been obtain and documented per physician orders, and that the facility could utilize the dry weight documented on the dialysis communication form from dialysis that day.</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 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>33305</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 and responded to in a timely manner by the attending physician or prescriber for two of 41 residents reviewed (Residents 90 and 144).</p> <p>Findings include:</p> <p>Review of facility policy, titled Medication Regimen Reviews, reviewed May 2024, revealed, 4. If the Attending Physician declines or otherwise rejects the Consultant Pharmacist's non-urgent Recommendation, an explanation as to the rationale for the rejection shall be documented in the Resident's medical record.</p> <p>Review of Resident 90's clinical record revealed diagnoses that included schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression) and anxiety disorder (group of mental health conditions characterized by excessive and persistent fear or worry, significantly impacting daily life and functioning).</p> <p>Review of Resident 90's electronic medical record on revealed a review of psychoactive medications, dated December 23, 2024, in which the pharmacist recommended a GDR (gradual dose reduction) for Resident 90's psychoactive medications. The physician responded to this request by the pharmacist by disagreeing. The physician failed to include a rationale for not attempting the GDR.</p> <p>Interview with the Director of Nursing (DON) on March 20, 2025, at 10:30 AM, revealed that they do not have any documents to show that a rationale was provided by the physician for disagreeing with the GDR attempt recommendation made for Resident 90 on December 23, 2025.</p> <p>Review of Resident 144's clinical record revealed diagnoses that included depressive disorder (a mental health condition characterized by persistent low mood, loss of interest, and other symptoms that can significantly impact daily life) and anxiety disorder.</p> <p>Review of Resident 144's electronic medical record revealed a review of psychoactive medications, dated August 25, 2024, in which the pharmacist recommended a GDR for Resident 144's psychoactive medications. The physician responded to this request by the pharmacist by disagreeing. The physician failed to include a rationale for not attempting the GDR and failed to date the response.</p> <p>Interview with the DON on March 20, 2025, at 10:40 AM, revealed that they do not have any documents to show that a rationale was provided by the physician for disagreeing with the GDR attempt recommendation made for Resident 144 on August 25, 2024.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37817</p> <p>Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to store and serve food/beverages in accordance with professional standards regarding the operation of the dish machine in the kitchen.</p> <p>Findings include:</p> <p>Review of facility policy, Dish Machine Temperatures, revised April 5, 2024, read, in part, dish machine final rinse temperatures should be maintained at temperature not less than those established by the Food and Drug Administration, high temperature dish machine will be no less than 180 degrees Fahrenheit (F).</p> <p>Observation of the dish machine on March 17, 2025, at 9:32 AM, the final rinse temperature registered 176 degrees F.</p> <p>Observation of the dish machine temperature log for March 1st through 17th, 2025, breakfast read, in part, the final rinse temperature was documented below 180 degrees F for all meals.</p> <p>During an interview with the Employee 8 (Food Service Director) on March 17, 2025, at 9:34 AM, it was revealed the final rinse temperature should be 180 degrees F . It was also revealed that the documented final rinse temperatures on the log were below the standard of 180 degrees F.</p> <p>During an interview with the Employee 1 (Assistant Nursing Home Administrator) on March 18, 2025, at 1:30 PM, it was revealed that the facility Maintenance Department repairs the dish machine, and a request was submitted to Maintenance to assess the final rinse temperature. It was also revealed that the facility utilized the incorrect temperature log and, therefore, the Dietary Department failed to submit a maintenance request to evaluate the final rinse temperature. It was confirmed that the final rinse temperature should be 180 degrees F, and that Maintenance did recalibrate the temperature for final rinse cycle.</p> <p>28 Pa code 211.6(f) - Dietary Services</p>		