

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/31/2024
NAME OF PROVIDER OR SUPPLIER  Wexford Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  9850 Old Perry Highway Wexford, PA 15090	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27424</b></p> <p>Based on review of facility documentation, observations, resident and staff interviews it was determined that the facility failed to offer residents the opportunity to vote for the May 2024 election and the facility failed to provide a dignified dining experience for one of three Residents (Resident R43).</p> <p>Findings include:</p> <p>Review of the facility policy Resident Rights dated 10/24/24, and previously dated 9/9/23, indicated that residents' care will be provided in a safe and respectful manner.</p> <p>Review of resident council meeting minutes for six months failed to include information of the facility asking the residents about voting.</p> <p>During a resident group on 10/30/24, at 11:40 a.m. residents indicated that they were not offered the ability to vote in this election (November 2024), and in past elections four residents indicated they wanted to vote.</p> <p>During an interview on 10/31/24, at 8:54 a.m. Activity Director Employee E9 confirmed that the facility failed to have documentation showing that all residents in the facility were asked about voting and could not find documentation for May of 2024 and that the facility failed to offer voting to all residents.</p> <p>Review of the clinical record revealed that Resident R43 was admitted to the facility on [DATE].</p> <p>Review of Resident 43's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 8/9/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and muscle weakness.</p> <p>Review of Resident R43's physician's order dated 5/3/24, indicated that Resident R43 requires self-feeding assistance during meals.</p> <p>During an observation on 10/27/24, at 1:03 p.m. Resident R43 was seated in her chair beside her bed while being fed by Nurse Aide (NA) Employee E20. NA Employee E20 was standing beside Resident R43 while she was feeding Resident R43.</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>During an interview on 10/27/24, at 1:04 p.m. NA Employee E20 confirmed that she failed to provide a dignified dining experience for Resident R43, as she was standing while feeding Resident R43.</p> <p>28 Pa. Code 201.1(i)Resident rights.</p>

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</b></p> <p>Based on review of facility policies, observations, resident and staff interviews, it was determined that the facility failed to determine the ability to self-administer medications for three of 10 residents (Residents R17, R50, and R71).</p> <p>Findings include:</p> <p>Review of facility policy Medication Administration dated 10/24/24, indicated a resident-centered, individualized approach to medication administration will be used for administering medications as possible. Safety and avoiding adverse effects are considered a high priority for medication administration and may preclude some preferences. Remain with resident until the medication is swallowed. Do not leave medication at bedside.</p> <p>Review of the clinical record revealed that Resident R17 was admitted to the facility on [DATE].</p> <p>Review of Resident R17's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 8/28/24, indicated diagnoses of high blood pressure, respiratory failure (when the lungs cannot get enough oxygen), and low back pain.</p> <p>Review of Resident R17's physician's order failed to include an order for self-administration of medications.</p> <p>Review of Resident R17's care plan on 10/27/24, failed to include self-administration of medication management.</p> <p>Review of Resident R17's clinical record indicated the absence of a Self-Administration of Medication assessment.</p> <p>During an observation on 10/27/24, at 10:21 a.m. Resident R17 was observed holding a medication cup full of medications in her hand and no nursing staff present in her room.</p> <p>During an interview on 10/27/24, at 10:23 a.m. Registered Nurse (RN) Employee E18 confirmed that Resident R17 was left unattended with medications.</p> <p>Review of the clinical record indicated Resident R50 was admitted to the facility on [DATE].</p> <p>Review of Resident R50's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety (a feeling of worry, nervousness, or unease), and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions).</p> <p>Review of a physician order dated 9/30/24, indicated to administer Lorazepam (a controlled medication used to treat anxiety) 0.5 milligrams every six hours for anxiety.</p> <p>Review of Resident R50's physician orders failed to include an order for self-administration of medications.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R50's care plan on 10/27/24, failed to include self-administration of medication management.</p> <p>Review of Resident R50's clinical record indicated the absence of a Self-Administration of Medication assessment.</p> <p>Review of a Behavior Note completed by RN Employee E5 stated, Resident R50's granddaughter was visiting when I brought her grandmother Ativan. As she was leaving, she approached me and expressed that the nurse should remain in the room while administering the Ativan; otherwise, her grandmother might not take it and will be climbing the walls. I reassured her that her grandmother consistently takes her medication in my presence, and the only reason I left the Ativan with her was that they were enjoying coffee together. On her way out, the granddaughter handed me an Ativan she found on the floor, expressing concern that previous nurses may have left pills in the room, resulting in her grandmother not receiving her medication. I explained that we had not noticed any behavioral issues with her grandmother, indicating she had been properly medicated. I also pointed out that her roommate had spilled a full cup of medications, which included Ativan, and it was more likely to belong to her. The granddaughter was skeptical of my explanation and requested to speak with the nursing supervisor.</p> <p>During an interview on 10/31/24, at 10:21 a.m. the Director of Nursing (DON) stated that the expectation is that nurses will remain with residents during medication administration and confirmed that RN Employee E5 should have remained with Resident R50 while administering Ativan.</p> <p>Review of the clinical record indicated Resident R71 was admitted to the facility on [DATE].</p> <p>Review of Resident R71's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety (a feeling of worry, nervousness, or unease), and unsteadiness on feet.</p> <p>Review of a physician order dated 12/4/23, indicated to apply Biofreeze External Gel 4% to posterior (back of) neck two times a day.</p> <p>Review of Resident R71's physician orders failed to include an order for self-administration of medications.</p> <p>Review of Resident R71's care plan on 10/27/24, failed to include self-administration of medication management.</p> <p>Review of Resident R71's clinical record indicated the absence of a Self-Administration of Medication assessment.</p> <p>During an observation on 10/27/24, at 9:36 a.m. a bottle of Biofreeze was observed on Resident R71's bedside table.</p> <p>During an interview on 10/27/24, at 10:10 a.m. RN Employee E1 confirmed that she left the bottle of Biofreeze in Resident R71's room.</p> <p>During an interview on 10/28/24, at 2:45 p.m. the DON confirmed that the facility failed to determine the ability to self-administer medications for three of 10 residents (Residents R17, R50, and R71).</p> <p>(continued on next page)</p>		

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F 0554  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	28 Pa. Code 201.14(a) Responsibility of Licensee.  28 Pa. Code: 211.10(c)(d) Resident care policies.  28 Pa. Code: 211.12(d)(1)(5) Nursing services.  28 Pa. Code: 211.9(a)(1) Pharmacy services.

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<p>F 0565</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 organize and participate in resident/family groups in the facility.</p> <p>27424</p> <p>Based on review of facility policy, resident council minutes, group and staff interview it was determined that the facility failed to respond to resident concerns and grievances identified during resident council meeting for six of six months reviewed (May 2024 to October 2024).</p> <p>Findings include:</p> <p>Review of facility policy dated 10/24/24, Resident Grievance indicated: Grievance: an official statement of a complaint over something believed to be wrong or unfair.</p> <p>Review of Resident Council minutes from May 2024 to October 2024 indicated the following concerns:</p> <p>5/7/24: call bells, 3/11 staff not giving good care, and staff not wearing name tags.</p> <p>6/4/24: agency aides don't know residents and are rude, want to know staff to resident ratio, why don't wear name tags and introduce themselves, and staff don't wear name tags.</p> <p>7/2/24: shortage in linens not smelling fresh, not enough oxygen on nursing unit, agency aides not answering call bells.</p> <p>8/6/24: shortage in linen, vending machine that accepts credit cards, staff not wearing name tags.</p> <p>9/3/24: vending machine that accepts credit cards, staff not wearing name tags, oxygen tanks on floors, some residents not getting showers.</p> <p>10/1/24: vending machine that accepts credit cards, staff wearing name tags and evening activities.</p> <p>Resident group meeting on 10/30/24, at 11:35 a.m. residents (total group) agreed that their concerns are on-going, they do not get answers or resolutions to their concerns but are told the facility is working on their concerns.</p> <p>During an interview on 10/31/24, at 8:45 a.m. Activity Director Employee E9, confirmed that there was no documentation to be provided for follow up of residents' concerns from resident council meetings, and that the facility failed to respond to resident concerns and grievances identified during resident council.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p>

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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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27424</b></p> <p>Based on a review of facility policy, clinical records, and staff interview it was determined the facility failed to notify the physician of a change of condition for one of eight residents (Resident R173).</p> <p>Findings include:</p> <p>Review of facility policy Notification of Change in Condition, dated 10/24/24, indicated Compliance Guidelines: The center must inform the resident, consult with the residents physician when there is a change requiring notification.</p> <p>Resident R173 was admitted to the facility on [DATE].</p> <p>Review of Resident R173 admit sheet indicated diagnosis of type II Diabetes Mellitus (chronic disease that occurs when the body doesn't use insulin properly, resulting in high blood sugar levels), and end stage renal dependence (permanent condition that occurs when the kidneys are no longer able to function).</p> <p>Review of clinical progress notes dated 10/19/24, indicated Trulicity Subcutaneous Solution Pen-injector ( a type 2 diabetes medication that helps your body release own insulin - given weekly) 0.75MG/0.5ML Inject 0.75mg subcutaneously one time a week every Saturday for DM (diabetes mellitus) - medication not available in house, called Pharmacy script syringe to be delivered soon as possible.</p> <p>Review of Resident R173 clinical record failed to show where medication was given.</p> <p>Review of Resident R173 record failed to indicate the physician was notified.</p> <p>During an interview on 10/31/24, at 8:47 a.m. Director of Nursing confirmed that the facility failed to notify the physician of Resident R173 not being given Trulicity as ordered once a week.</p> <p>28 Pa. Code 201.14(a)ce Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)e(1)Management.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>50075</p> <p>Based on review of facility policy, observations, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information for three out of six resident rooms (Resident R12, R75, and R83), and one out of four medication carts (100 RP Wing Med cart).</p> <p>Findings include:</p> <p>The facility Health Insurance Portability and Accountability Act (HIPAA) policy dated 10/24/24, indicated that the facility requires providers and others to implement security measures to guard the integrity and confidentiality of medical information.</p> <p>During a tour on 10/27/24, at 9:45 a.m. the following was observed:</p> <p>At 9:47 a.m. Resident R12's room was observed with a sign beside his bed which stated Float heels when in bed with use of heel boots and wedge/pillow to maintain heels off bed at all times.</p> <p>At 9:55 a.m. Resident R75's room was observed with a sign above her bed which stated Upright for all oral intake, open all containers, cut food into bite size pieces, put straws in liquids, make sure food is within reach, remove garbage from tray, go in during meal and encourage her to eat.</p> <p>At 10:15 a.m. Resident R83's room was observed with a sign above her bed which stated Upright for all food/drink, small single bites, at times she is more willing to drink then eat-so if she is not eating offer drinks, offer liquids via straw.</p> <p>During an interview on 10/27/24, at 2:25 p.m. Licensed Practical Nurse Employee E6 stated, I don't know who put the signs up but they should not be there.</p> <p>During an interview on 10/27/24, at 2:45 p.m. the Director of Nursing (DON) confirmed that the facility failed to maintain the confidentiality of residents' medical information for three out of six resident rooms (Residents R12, R75, and R83).</p> <p>During a medication administration observation on 10/28/24, at 8:49 a.m. Registered Nurse (RN) Employee E7 walked away from the medication cart that was across the hallway to administer medication and left the computer screen open for any passerby to see confidential information.</p> <p>During an interview on 10/28/24, at 2:45 p.m. DON confirmed that that the facility failed to maintain the confidentiality of residents' medical information for two out of four medication carts (100 RP Wing Med cart).</p> <p>28 Pa. Code 201.29(j) Resident rights.</p> <p>28 Pa. Code 211.5(b) Clinical records.</p>		

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<p>F 0585</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 voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35785</p> <p>Based on review of facility policy, resident council interview, observations of resident areas and nursing units, and staff interviews it was determined that the facility failed to ensure anonymous grievance forms are readily accessible for resident use on one of three floors (Second floor).</p> <p>Findings include:</p> <p>The facility Resident grievance policy dated 2/20/24, indicated that the facility will maintain a secure box, in an area accessible to residents and visitors, for reporting grievances in writing and anonymously. Multiple boxes may be required in the facility to ensure that all residents are able to exercise their right to file grievances anonymously.</p> <p>During a resident group interview on 10/30/24, at 11:45 a.m the residents stated they do not know where the grievance box is, where the concern forms are or who the grievance officer is.</p> <p>During observations on 10/31/24, at 9:42 a.m. observations of the Second floor D-wing lounge was observed locked. A sign was observed on the outside of the door and it stated: closed for renovation. The Second floor D-wing lounge was observed with the facility grievance box and it was observed empty without any grievance forms.</p> <p>During observations on 10/31/24, at 9:46 a.m. the Lounge across from room [ROOM NUMBER] was observed without a grievance box or forms for resident use.</p> <p>During observations on 10/31/24, at 9:49 a.m. the Second floor Savor lounge was observed without any grievances box or grievance form for resident use.</p> <p>During an interview on 10/31/24, at 11:30 a.m. Nursing Home Administrator (NHA) confirmed that the facility failed to have a private grievance box available to residents, with the grievance box on the second floor being in the second floor lounge which is inaccessible to residents due to renovations.</p> <p>During an exit interview on 10/31/24, at 5:10 p.m. information was disseminated to the Nursing Home Administrator (NHA) and the Director of Nursing (DON) that the facility failed to ensure anonymous grievance forms are readily accessible for resident use on the Second floor.</p> <p>28 Pa. Code 201.29(l)Resident rights.</p> <p>28 Pa. Code 201.18e(4)Management.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50075</p> <p>Based on review of facility documents, facility policy, clinical records, resident representative interview, and staff interviews, it was determined that the facility failed to provide appropriate goods and services to prevent physical neglect for two of four residents (Resident R87 and R107).</p> <p>Findings include:</p> <p>Review of facility Abuse, Neglect and Misappropriation policy dated 9/9/23 and 10/24/24, indicated it is the policy of the facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. It is the intent of the facility to prevent abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property.</p> <p>Review of the clinical record indicated Resident R87 was admitted to the facility on [DATE].</p> <p>Review of Resident R87's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/27/24, indicated diagnoses of high blood pressure, depression, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section GG0130 is coded as a 1, indicating dependent for toileting hygiene.</p> <p>Review of Resident R87's care plan dated 9/30/24, indicated toileting hygiene - Dependent. Helper does all of the effort or two or more helper assists.</p> <p>During an interview on 10/27/24, at 12:26 p.m. a resident representative reported an allegation of neglect to State Agency concerning incontinent care being completed timely and that evening shift is the worse shift. During allegation of neglect, it was reported that resident was not changed for nine hours on 10/16/24.</p> <p>During an interview on 10/27/24, at 1:15 p.m. the Nursing Home Administrator stated he was familiar with the neglect allegation and was able to provide documentation dated 10/17/24, regarding the investigation that was conducted related to the event.</p> <p>During review of documentation provided by the facility on 10/28/24, at 10:35 a.m. indicated that the resident was observed to have been incontinent. This was observed by resident representative and other staff members once it was brought to their attention. The incident was discussed with the employee assigned to resident in which she responded, I had not changed her since earlier in the morning.</p> <p>During review of documentation provided by the facility on 10/28/24, at 11:02 a.m. indicated that the facility substantiated the allegation of neglect that was made for Resident R87.</p> <p>During an interview on 10/30/24, at 10:15 a.m. Nursing Home Administer (NHA) stated We did the investigation and the alleged perpetrator resigned from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/30/24, at 10:37 a.m. NHA confirmed that the facility failed to ensure that residents were free from neglect for Resident R87.</p> <p>Review of the clinical record revealed that Resident R107 was admitted to the facility on [DATE].</p> <p>Review of Resident 107's MDS dated [DATE], indicated diagnoses of high blood pressure, intracerebral hemorrhage (when a ruptured blood vessel causes bleeding inside the brain), and dysphagia (difficulty swallowing).</p> <p>Review of Resident R107's clinical record revealed a progress note from Physician Assistant (PA) Employee E34 dated 10/30/24, at 5:36 p.m. that stated the following: Very critical K (potassium level) in a non-verbal patient. Full code. Will transfer to ER (emergency room ). K was 5.5 on the 10/29/24, now 6.8. Transfer to ER.</p> <p>Review of Resident R107's clinical record revealed a nursing progress note dated 10/31/24, at 9:20 a.m. that stated the following: To go into ER due to elevated potassium.</p> <p>During an observation on 10/31/24, at approximately 9:30 a.m. State Agency witnessed Resident R107 being transferred into an ambulance.</p> <p>During an interview on 10/31/24, at 12:53 p.m. PA Employee E34 stated that she had been contacted the evening of 10/30/24, regarding Resident R107's high potassium level via a telehealth visit in which she instructed the nurse who contacted her to send Resident R107 to the hospital. When PA Employee E34 was asked if she meant for Resident R107 to be sent to the hospital the following morning, she replied No. I wanted her sent out right then. PA Employee E34 added that the conversation with facility staff and the contents of the consult are recorded and that there are audio files to support her instructions.</p> <p>During an interview on 10/31/24, at 2:22 p.m. the Director of Nursing (DON) confirmed that Resident R107 was not sent out to the hospital on the evening of 10/30/24, as instructed, and that the expectation would have been to send Resident R107 to hospital directly after having received the order to do so. DON confirmed that the facility neglected to address Resident R107's change in condition in a timely manner.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee</p> <p>28. Pa Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 201.29(j) Resident rights.</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:  395300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/31/2024
NAME OF PROVIDER OR SUPPLIER  Wexford Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  9850 Old Perry Highway Wexford, PA 15090	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of facility policy, clinical record review, reports submitted to the State, and resident and staff interviews, it was determined that the facility failed to report allegations of neglect in the required timeframe one of three residents (Resident R48).</p> <p>Findings include:</p> <p>Review of facility policy Abuse, Neglect and Misappropriation dated 10/24/24, indicated neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. For alleged violations of neglect, exploitation, misappropriation of resident property, or mistreatment that do not result in serious bodily injury, the facility must report the allegation no later than 24 hours.</p> <p>Review of the clinical record indicated Resident R48 was admitted to the facility on [DATE].</p> <p>Review of Resident R48's MDS dated [DATE], indicated diagnoses of neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination), and quadriplegia (paralysis of all four limbs).</p> <p>During an interview on 10/27/24, at 10:37 a.m. Resident R48 stated, I didn't have my call bell available last night from 11 p.m. to 5 a.m. No one rounded on me last night from 11 p.m. to 5 a.m. The aide who put me to bed last night around 9 p.m. did it by herself, she used a Hoyer (a mechanical lift) to put me back to bed by herself when there should have been two people. The aide I have today told me that she would get me up yesterday before lunch and shave me. She didn't get me up until after lunch and she didn't shave me because she said I was rude.</p> <p>During an interview on 10/27/24, at 11:28 a.m. the Nursing Home Administrator (NHA) and Director of Nursing (DON) were made aware by the State Agency of the allegations of neglect that Resident R48 had made during an interview on 10/27/24, at 10:37 a.m.</p> <p>A review of incidents submitted to the State on 10/28/24, at 1:28 p.m. included Resident R48's allegation that an aide failed to shave him, but failed to include the neglect allegations involving not having his call bell available and not being rounded on by nursing staff for six hours and the allegation that one aide used a Hoyer lift to put him back to bed.</p> <p>During an interview on 10/29/24, at 2:35 p.m. the DON confirmed that the facility failed to report allegations of neglect in the required timeframe as required for one of three residents (Resident R48).</p> <p>28 Pa. Code 201.14(a)(c).(e.) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Wexford Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  9850 Old Perry Highway Wexford, PA 15090	

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F 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa. Code 201.20(b) Staff development.  28 Pa. Code 211.10(c).(d) Resident care policies.

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on clinical record review, facility policy, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for six of six residents with facility-initiated transfers (Residents R20, R36, R41, R42, R48, and R101).</p> <p>Findings include:</p> <p>Review of facility policy Transfer and Discharge Policy dated 9/19/23, last reviewed 10/24/24, indicated information provided to the receiving provider must include a minimum of the following: contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, advance directive information, all special instructions or precautions for ongoing care as appropriate, comprehensive care plan goals, and all other necessary information, including a copy of the residents discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>Review of the clinical record indicated Resident R20 was admitted to the facility on [DATE].</p> <p>Review of Resident R20's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/10/24, indicated diagnoses of high blood pressure, depression, and heart failure (a progressive heart disease that affects pumping action of the heart muscles).</p> <p>Review of Resident R20's clinical record indicated the resident was transferred to the hospital on 2/6/24.</p> <p>Review of Resident R20's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of the clinical record indicated Resident R36 was admitted to the facility on [DATE].</p> <p>Review of Resident R36's MDS dated [DATE], indicated diagnoses of high blood pressure, hyponatremia (low levels of sodium in the blood), and unsteadiness on feet.</p> <p>Review of Resident R36's clinical record indicated the resident was transferred to the hospital on 7/4/24.</p> <p>Review of Resident R36's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE].</p> <p>Review of Resident R41's MDS dated [DATE], indicated diagnoses of high blood pressure, peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and dependence on supplemental oxygen.</p> <p>Review of Resident R41's clinical record indicated the resident was transferred to the hospital on 1/11/24.</p> <p>Review of Resident R41's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility</p> <p>Review of the clinical record indicated Resident R42 was admitted to the facility on [DATE].</p> <p>Review of Resident R42's MDS dated [DATE], indicated diagnoses of anemia (low iron in the blood), atrial fibrillation(A-fib- irregular and rapid heartbeat), and heart failure (failure of the heart to function properly).</p> <p>Review of Resident R42's clinical record indicated the resident was transferred to the hospital on 10/1/24.</p> <p>Review of Resident R42's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of the clinical record indicated Resident R48 was admitted to the facility on [DATE].</p> <p>Review of Resident R48's MDS dated [DATE], indicated diagnoses of neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination), and quadriplegia (paralysis of all four limbs).</p> <p>Review of Resident R48's clinical record indicated the resident was transferred to the hospital on 5/28/24.</p> <p>Review of Resident R48's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of the clinical record indicated Resident R101 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R101's MDS dated [DATE], indicated diagnoses of depression, muscle weakness, and cancer (occurs when cells in the body grow and divide uncontrollably, which can lead to the development of tumors and the spread of disease throughout the body).</p> <p>Review of Resident R101's clinical record indicated the resident was transferred to the hospital on 1/16/24.</p> <p>Review of Resident R101's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>During an interview on 10/30/24, at 2:52 p.m. the Director of Nursing confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer as required for six of six residents with facility-initiated transfers (Residents R20, R36, R41, R42, R48, and R101).</p> <p>28 Pa. Code 201.29 (a)(c.3)(2) Resident rights.</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>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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</b></p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization ) for six of six resident hospital transfers (Residents R20, R36, R41, R42, R48, and R101).</p> <p>Findings include:</p> <p>Review of facility policy Bed Hold Policy dated 9/19/23, and last reviewed 10/24/24, indicated it is the intent of the facility to obtain the proper authorization to hold a resident bed when the resident returns to the hospital or goes on a leave. The bed hold authorization form may be signed prior to the patient leaving the building, or within 24 hours of the resident leaving the facility or the following business day if the resident leaves on the weekend or a holiday. If applicable according to state law if the bed hold authorization form cannot be signed prior to the resident leaving and needs to be mailed, it must be mailed certified return receipt requested by the Business Office Manager or designee. The Admissions Director or designee will notify the resident and/or responsible party of the days available under their Medicaid benefits or the private pay cost associated with holding the bed will be explained, within 24 hours of the patient leaving the facility, or the following business day if the patient leaves on the weekend or a holiday.</p> <p>Review of the clinical record indicated Resident R20 was admitted to the facility on [DATE].</p> <p>Review of Resident R20's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/10/24, indicated diagnoses of high blood pressure, depression, and heart failure (a progressive heart disease that affects pumping action of the heart muscles).</p> <p>Review of Resident R20's clinical record indicated the resident was transferred to the hospital on 2/6/24, and returned to the facility on [DATE].</p> <p>Review of Resident R20's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 2/6/24.</p> <p>Review of the clinical record indicated Resident R36 was admitted to the facility on [DATE].</p> <p>Review of Resident R36's MDS dated [DATE], indicated diagnoses of high blood pressure, hyponatremia (low levels of sodium in the blood), and unsteadiness on feet.</p> <p>Review of Resident R36's clinical record indicated the resident was transferred to the hospital on 7/4/24, and returned to the facility on [DATE].</p> <p>Review of Resident R36's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 7/4/24.</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>Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE].</p> <p>Review of Resident R41's MDS dated [DATE], indicated diagnoses of high blood pressure, peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and dependence on supplemental oxygen.</p> <p>Review of Resident R41's clinical record indicated the resident was transferred to the hospital on 1/11/24, and returned to the facility on [DATE].</p> <p>Review of Resident R41's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 1/11/24.</p> <p>Review of the clinical record indicated Resident R42 was admitted to the facility on [DATE].</p> <p>Review of Resident R42's MDS dated [DATE], indicated diagnoses of anemia (low iron in the blood), atrial fibrillation (A-fib- irregular and rapid heartbeat), and heart failure (failure of the heart to function properly).</p> <p>Review of Resident R42's clinical record indicated the resident was transferred to the hospital on 10/1/24, and returned to the facility on [DATE].</p> <p>Review of Resident R42's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 10/1/24.</p> <p>Review of the clinical record indicated Resident R48 was admitted to the facility on [DATE].</p> <p>Review of Resident R48's MDS dated [DATE], indicated diagnoses of neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination), and quadriplegia (paralysis of all four limbs).</p> <p>Review of Resident R48's clinical record indicated the resident was transferred to the hospital on 5/28/24, and returned to the facility on [DATE].</p> <p>Review of Resident R48's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 5/28/24.</p> <p>Review of the clinical record indicated Resident R101 was admitted to the facility on [DATE].</p> <p>Review of Resident R101's MDS dated [DATE], indicated diagnoses of depression, muscle weakness, and cancer (occur when cells in the body grow and divide uncontrollably, which can lead to the development of tumors and the spread of disease throughout the body).</p> <p>Review of Resident R101's clinical record indicated the resident was transferred to the hospital on 1/16/24, and returned to the facility on [DATE].</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>Review of Resident R101's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 1/16/24.</p> <p>During an interview on 10/30/24, at 2:52 p.m. the Director of Nursing confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for six of six resident hospital transfers as required for six of six resident hospital transfers (Residents R20, R36, R41, R42, R48, and R101).</p> <p>28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785</b></p> <p>Based on review of clinical records and observations, as well as staff and resident interviews, it was determined that the facility failed to provide Activity of Daily Living (ADL) assistance for four out of nine sampled residents (Resident R27, R46, R48, and R87).</p> <p>Findings include:</p> <p>The facility Routine resident care policy dated 9/19/23, indicated that routine resident care is not necessarily clinical, but is necessary for quality of life. Provide routine daily care by a certified nursing assistant. Routine care includes but is not limited to the following: bathing, dressing and toileting.</p> <p>Review of Resident R27's admission record indicated he was originally admitted on [DATE], and readmitted on [DATE].</p> <p>Review of Resident R27's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 6/18/24, indicated that he had diagnoses that included diabetes (a metabolic disorder impacting organ function related to glucose levels in the human body), peripheral vascular disease (PVD- a narrowing of the blood vessels in the legs), hypertensive heart disease (a condition characterized by long term heart conditions and high blood pressure), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), and spinal stenosis (a narrowing of the spaces within the spine, which causes pain and weakness). The diagnoses were current upon review.</p> <p>Review of Resident R27's MDS assessment dated [DATE], indicated that Section GG0100A-Self care (resident's need for assistance with bathing, dressing, using the toilet) was coded 2 for help needed from another person.</p> <p>Review of Resident R27's care plan dated 6/20/24, indicated that Resident R27 was dependent for shower/bathe. Helper does all of the effort with two or more staff.</p> <p>Review of Resident R27's October 2024 shower documentation indicated there was no shower provided on 10/2/24, 10/26/24, and 10/30/24.</p> <p>During an interview on 10/27/24, at 1:10 p.m. Resident R27 was interviewed and stated the following: I never had my beard trimmed. The Nurse aide did not get me a shower last night and they do not want to do showers.</p> <p>Review of clinical record indicated that Resident R46 was admitted on [DATE].</p> <p>Review of Resident R46's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and muscle weakness.</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 - Some</p>	<p>Review of Resident R46's MDS assessment dated [DATE], indicated that Section GG0100A-Self-care (resident's need for assistance with bathing, dressing, using the toilet) was coded 2 for help needed from another person.</p> <p>Review of Resident R46's care plan dated 9/10/24, indicated that Resident R46 was dependent for shower/bathe. Helper does all of the effort with assistance of one person.</p> <p>Review of Resident R46's October 2024 shower documentation indicated there was no shower provided on 10/10/24, 10/14/24, and 10/28/24.</p> <p>Review of the clinical record indicated Resident R48 was admitted to the facility on [DATE].</p> <p>Review of Resident R48's MDS dated [DATE], indicated diagnoses of neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination), and quadriplegia (paralysis of all four limbs). Section GG - Functional Abilities and Goals, Question GG01130E - Shower/bathe self: indicated Resident R48 was coded 1 dependent, helper does all of the effort.</p> <p>Review of Resident R48's care plan dated 6/4/24, indicated that Resident R48 was dependent for shower/bathe. Helper does all of the effort with two or more staff.</p> <p>Review of Resident R48's October 2024 shower documentation indicated there was no shower or bath provided on 10/3/24, 10/7/24, 10/10/24, 10/14/24, 10/21/24, 10/24/24, and 10/28/24.</p> <p>During an interview on 10/27/24, at 10:18 a.m. Resident R48 stated, I go three weeks without getting a shower. I'm supposed to get showers on Mondays and Thursdays, I have never gotten a shower twice a week here.</p> <p>Review of Resident R87's admission record indicated he was admitted to the facility on [DATE].</p> <p>Review of Resident R87's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).</p> <p>Review of Resident R87's care plan dated 9/30/24, indicated that Resident R87 was dependent for shower/bathe. Helper does all of the effort with two or more staff.</p> <p>Review of Resident R87's September 2024 shower documentation indicated no showers were provided since admission.</p> <p>Review of Resident R87's October 2024 shower documentation indicated no shower was provided on 10/3/2024, 10/10/2024, 10/17/2024, 10/21/24, 10/24/24, and 10/28/24.</p> <p>During an interview on 10/30/24, at 2:52 p.m the Director of Nursing (DON) confirmed that the facility failed to provide Activity of Daily Living (ADL) assistance for Residents R27, R46, R48, and R87, as required.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(e)(6) Management.</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 - Some</p>	<p>28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.</p> <p>28 Pa. Code: 201.20 Staff development.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</b></p> <p>Based on a review of the clinical record and staff interviews, it was determined that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for six of six residents (Residents R1 and R112 and Residents R200, R201, R202, and R203).</p> <p>Findings include:</p> <p>Review of facility policy Activities Program dated 9/19/23, and last reviewed 10/24/24, indicated the facility is to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. The activity program is designed to encourage restoration to self-care and maintenance of normal activity that is geared to the individual resident's needs. The activity program consists of individual and small and large group activities which are designed to meet the needs and interests of each resident and includes social activities, indoor and outdoor activities, activities away from the facility, religious programs, creative activities, intellectual and educational activities, exercise activities, individualized activities, in-room activities, and community activities.</p> <p>During a resident group interview on 10/30/24, at 11:16 a.m. Residents R200, R201, R202 and R204 indicated that the activities don't always meet their needs. Residents stated that the activity calendar can change and activities don't take place, and they are unaware of when the changes are going to take place.</p> <p>Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].</p> <p>Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/9/24, indicated diagnoses of high blood pressure, muscle weakness, and dependence on wheelchair.</p> <p>Review of Resident R1's care plan dated 2/23/24, indicated the resident will participate in socialization and recreation activities to decrease isolation, improve mood, and increase peer interaction. Interventions include provide socialization, leisure, and/or recreation activities per the resident's wishes and to offer and encourage attendance and involvement in facility activities.</p> <p>During an interview on 10/27/24, at 9:59 a.m. Resident R1 stated, The facility has a lot of group activities but I am unable to participate in them currently. No one from Activities comes in to do activities with me in my room, but I would like them to.</p> <p>Review of Resident R1's clinical record for October 2024, revealed the facility failed to provide an ongoing program of activities to meet the resident's interests. Review of Resident R1's Activity Participation indicated that no activities were offered to Resident R1 during October of 2024.</p> <p>Review of the clinical record indicated Resident R112 was admitted to the facility on [DATE].</p> <p>Review of the clinical record MDS dated [DATE], indicated Resident R112 was admitted with the following diagnosis cerebral palsy, and epilepsy.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/29/24, at 9:24 a.m. Resident R112 indicated that she enjoys activities, but they don't come in the room anymore.</p> <p>Review of Resident R112 MDS dated [DATE], activities and preferences indicated activity preferences of:music,animals and favorite activities. No care plan was indicated for activities.</p> <p>Review of Resident R112 clinical documentation for September, and October failed to indicate any activities were provided.</p> <p>During an interview on 10/31/24, at 8:55 a.m. Activities Director Employee E9 confirmed that activities have changed without notifying residents.</p> <p>During an interview on 10/31/24, at 9:06 a.m. Activities Director Employee E9 stated, Some resident's don't like to come out of their rooms. I ask them what they like to do and I try to bring them activities that they would like. I do not recall doing activities with Resident R1 in her room. She has never participated in group activities.</p> <p>During an interview on 10/31/24, at 9:13 a.m. Activities Director Employee E9 confirmed there was no documentation to indicate that Resident R1 was offered activities during October 2024.</p> <p>During an interview on 10/31/24, at 9:10 a.m. Activities Director Employee E9 confirmed there was no documentation to indicate that resident R112 was offered activities during September and October 2024.</p> <p>During an interview on 10/31/24, at 9:13 a.m. Activities Director Employee E9 confirmed that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for two of six residents (Residents R1, R112, and Residents R200, 201, 202, and 203).</p> <p>28 Pa. Code: 201. 18(b)(3) Management.</p> <p>28 Pa. Code: 207.2(a) Administrators Responsibility.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35785</p> <p>Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels as per physician's order for two of three sampled residents (Residents R5 and R88) and failed to document appropriate interventions for a resident with hypoglycemia (low blood glucose) for one of three sampled residents (Resident R5).</p> <p>Findings include:</p> <p>The facility Blood glucose point of care policy dated 9/19/23, indicated that point of care testing for blood glucose levels is a lab test that is performed at the bedside by a nurse. Record results and contact provider per physician orders if out of range.</p> <p>The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it's untreated for long periods of time, you can damage your nerves, blood vessels, tissues, and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds.</p> <p>Review of Resident R5's admission record indicated she was admitted on [DATE], and readmitted on [DATE].</p> <p>Review of Resident R5's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 5/24/24, indicated she had diagnoses that included diabetes (a metabolic disorder impacting organ function related to glucose levels in the human body), chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination), hypertension (a condition impacting blood circulation through the heart related to poor pressure), and chronic obstructive pulmonary disease (COPD: a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs). These diagnoses were current upon review.</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 R5's care plan dated 4/4/24, indicated to administer insulin injections per orders.</p> <p>Review of Resident R5's physician orders dated 8/23/24, indicated to administer insulin (Aspart) subcutaneously with blood glucose monitoring, provide medication before meals three times per the following protocol:</p> <p>0-70= notify the physician</p> <p>70-140 = 0 units</p> <p>141-180 = 2 units</p> <p>181-220 =4 units</p> <p>221-260 = 6 units</p> <p>261-300 = 8 units</p> <p>301-400 = 10 units</p> <p>401-999 = 12 units and call physician</p> <p>Review of Resident R5's vitals records from June 2024 to July 2024, indicated the following blood glucose measurements:</p> <p>7/9/24= 64 mg/dl</p> <p>10/6/24= 417 mg/dl</p> <p>10/7/24= 64 mg/dl</p> <p>10/9/24= 427 mg/dl</p> <p>Review of Resident R5's clinical records and physician documents did not include notifications to the physician as ordered related to the abnormal blood glucose levels on 7/9/24, 10/6/24, 10/7/24, and 10/9/24.</p> <p>Review of Resident R5's clinical records, nurse notes and physician documents did not include interventions for hypoglycemia for 10/7/24.</p> <p>During an interview on 10/29/24, at 11:05 a.m. Registered Nurse (RN) Employee E4 confirmed that the facility failed to notify a physician of increased and decreased Capillary Blood Glucose (CBG) levels as per physician's order and failed to document appropriate interventions for Resident R5 as required.</p> <p>Review of the clinical record indicated Resident R88 was admitted to the facility on [DATE], and readmitted on [DATE].</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 R88's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and muscle weakness.</p> <p>Review of a physician order dated 10/9/24, indicated to check the resident's blood sugar level before meals and at bedtime. Notify provider if blood sugar is less than 70 mg/dL or greater than 250 mg/dL.</p> <p>Review of Resident R88's care plan dated 5/31/24, indicated to administer insulin injections per orders.</p> <p>Review of Resident R88's vitals records for October 2024, indicated the following blood glucose measurements:</p> <p>10/27/24 12:26 p.m. = 252.0 mg/dL</p> <p>10/26/24 8:13 p.m. = 389.0 mg/dL</p> <p>10/24/24 8:49 p.m. = 375.0 mg/dL</p> <p>10/24/24 4:15 p.m. = 288.0 mg/dL</p> <p>10/21/24 9:23 p.m. = 367.0 mg/dL</p> <p>10/21/24 12:31 p.m. = 287.0 mg/dL</p> <p>10/20/24 8:28 p.m. = 340.0 mg/dL</p> <p>10/19/24 9:15 p.m. = 325.0 mg/dL</p> <p>10/19/24 4:21 p.m. = 305.0 mg/dL</p> <p>Review of Resident R88's progress notes from 10/19/24, through 10/27/24, failed to include documentation that a physician was notified of Resident R88's abnormal blood glucose levels on the dates listed above.</p> <p>During an interview on 10/29/24, at 2:10 p.m. the Director of Nursing confirmed that the facility failed to follow physician orders and notify a physician of abnormal blood glucose readings for Resident R88 as ordered.</p> <p>28 Pa. Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 201.29(a) Resident Rights</p> <p>28 Pa. Code 211.10 (c)(d) Resident Care policies</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49469</p> <p>Based on observations and resident and staff interviews, it was it was determined that the facility failed to obtain physician orders for negative pressure wound therapy devices (NPWT or wound vac - used to draw out fluid and infection from a wound to help it heal) for one of three residents (Resident R107), and failed to obtain physician treatment orders for an as needed dressing for one of three residents (Resident R64).</p> <p>Findings include:</p> <p>Review of facility policy Skin Care and Wound Management dated 9/19/23, last reviewed 10/24/24, indicated residents admitted with or develop skin integrity issues will receive treatment and as indicated.</p> <p>Review of facility policy Physician Orders dated 9/19/23, last reviewed 10/24/24, indicated it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the resident.</p> <p>Review of the admission record indicated Resident R107 was readmitted to the facility on [DATE].</p> <p>Review of Resident R107's Minimum Data Set (MDS- a periodic assessment of care needs) dated 10/7/24, indicated the diagnoses of hypertension (high blood pressure), anemia (low iron in the blood) and neurogenic bladder (nervous system condition that affects the way the bladder works). Section M - Wound care, M1200E indicated that Resident R107 received pressure ulcer/injury care.</p> <p>Review of Resident R107's physician order dated 10/28/24, indicated: cleanse sacrum with 0.125% dakins solution apply NPWT at 125mmhg cover with transparent film. Change Monday, Wednesday, Friday and as needed every day shift. Monitor to make sure it is running at all times. Start date 10/30/24.</p> <p>During an interview on 10/30/24, at 11:39 a.m. Registered Nurse (RN) Employee E18 confirmed the facility failed to obtain orders for the wound vac that included the frequency for the suction setting and interventions for treatment for displacement or malfunction of the wound vac.</p> <p>Review of the admission record indicated Resident R64 was readmitted to the facility on [DATE].</p> <p>Review of Resident R64's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/28/24 indicated the diagnosis of hypertension (high blood pressure), anemia (low iron in the blood) and diabetes (high sugar in the blood). Section M - Wound care, M1200E indicated that Resident R64 received pressure ulcer/injury care.</p> <p>Review of Resident R64's physician orders dated 10/23/24 indicated right lateral malleolus (heel) cleanse with wound cleanser, apply Medi-honey and silver alginate and cover with border gauze. every day shift Monday, Wednesday, Friday for Wound Care</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview completed on 10/29/24, at 9:45 a.m. Licensed Practical Nurse (LPN) Employee E6 stated I did it yesterday and Sunday I did it two days in row and confirmed the facility failed to obtain physician treatment orders for an as needed dressing for one of three residents (Resident R64).</p> <p>28 Pa. Code: 201.29(i) Resident Rights.</p> <p>28 Pa. Code 211.10(c)(d) Resident Care Policies.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785</b></p> <p>Based on review of facility policy, resident clinical records, resident and staff interview, it was determined that the facility failed to provide adequate and timely podiatry care for one of three sampled residents (Resident R27).</p> <p>Findings include:</p> <p>The facility Foot care policy dated 9/19/23, indicated that it is the policy to provide resident centered care. Foot care will be provided by nursing personnel for those residents unable to perform the task. Diabetic residents and those with chronic circulatory problems will be treated by licensed professionals</p> <p>Review of Resident R27's admission record indicated he was originally admitted on [DATE], and readmitted on [DATE].</p> <p>Review of Resident R27's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 6/18/24, indicated that he had diagnoses that included diabetes (a metabolic disorder impacting organ function related to glucose levels in the human body), peripheral vascular disease (PVD- a narrowing of the blood vessels in the legs), hypertensive heart disease (a condition characterized by long term heart conditions and high blood pressure), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), and spinal stenosis (a narrowing of the spaces within the spine, which causes pain and weakness). The diagnoses were current upon review.</p> <p>Review of Resident R27's care plan dated 6/20/24, indicated to observe Resident R27 for edema of legs and feet.</p> <p>Review of Resident R27's clinical records and consultation visits did not include routine podiatry services.</p> <p>During observations on 10/27/24. at 12:00 p.m. Resident R27 was observed in his bed. His left leg was observed purple below the left knee and around his left calf.</p> <p>During an interview on 10/27/24, at 1:10 p.m. Resident R27 was interviewed and stated the following: I never had my beard trimmed. There is no barber in this place. No podiatrist either.</p> <p>During an interview on 10/29/24, at 9:25 a.m. Receptionist/Ancillary services coordinator Employee E13 stated the following: I coordinate the podiatry lists. The podiatrist separately bills the insurance company. Resident R27 is not on my list at all. Podiatry comes in twice a month. If a nurse notices someone needs seen, they will asks me to put them on the podiatry list.</p> <p>During an interview on 10/29/24, at 1:14 p.m. Receptionist/Ancillary services coordinator Employee E13 stated: the Podiatrist contacted me and stated that he has never seen Resident R27. He was never placed on the podiatry list.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/29/24, at 2:35 p.m. the Director of Nursing (DON) stated there were no documented refusal of podiatry services from Resident R27, and information relayed was relayed to DON that the facility failed to provide adequate and timely podiatry care to Resident R27 as required.</p> <p>28 Pa. Code 211.12(d)(1)(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 - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to perform timely and accurate post-fall documentation and failed to ensure that a resident received neurological assessments after an incident involving a fall for one of five residents (Resident R50).</p> <p>Findings include:</p> <p>Review of facility policy Fall Prevention and Management dated 9/19/23, and last reviewed 10/24/24, indicated after a resident fall, staff should complete the Post Fall Assessment. If the resident hit their head or the fall was unwitnessed, complete Neuro Checks per policy. Complete the Fall Follow Up at least twice each day for three days unless the resident's condition is such that it should be continued longer.</p> <p>Review of the clinical record indicated Resident R50 was admitted to the facility on [DATE].</p> <p>Review of Resident R50's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety (a feeling of worry, nervousness, or unease), and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions).</p> <p>Review of a Telehealth Notification note dated 9/16/24, at 11:04 p.m. completed by Nurse Practitioner Employee E22 stated, Nurse called to report unwitnessed fall. Contusion (bruise) to right side of head with small bump. Range of motion within normal limits for patient. Neuro checks normal. May use ice pack and Tylenol. Call with acute changes.</p> <p>Review of a nursing progress note dated 9/17/24 at 12:06 a.m. completed by Registered Nurse (RN) Employee E21 stated, Resident had an unwitnessed fall, she said she is trying to fix the bedside table then she slipped and fell . Contusion (bruise) noted on the right side on her head, ROM (range of motion) normal, vitals normal. Supervisor informed, called physician. Supervisor, informed hospice as well as the family member.</p> <p>Review of Resident R50's clinical record failed to indicate that a Post Fall Assessment was completed after the resident's unwitnessed fall on 9/16/24.</p> <p>Review of a Neuro Check Eval indicated neurological assessments should be performed every 15 minutes for one hour, every one hour for four hours, and every four hours for 16 hours, and then daily for four days.</p> <p>Review of Resident R50's Neuro Check Eval dated 9/16/24, indicated only 11 neurological checks were completed out of 16 opportunities.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Wexford Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  9850 Old Perry Highway Wexford, PA 15090	

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a nursing progress note dated 9/23/24 at 11:30 p.m. completed by RN Employee E23 stated, I was notified of the resident having had a fall. The roommate notified the nurse aide that the resident had fallen and gotten herself back up and in bed. VS wnl (vital signs within normal limits). She stated she slid into chair, fell back onto wheelchair while returning from bathroom. Called physician, notified RP (responsible party). Neuro checks started per protocol. No new orders, unless change of condition.</p> <p>Review of Resident R50's clinical record indicated that the Post Fall Assessment and Fall Follow Up were completed by RN Employee E24 on 10/5/24. Review of the Post Fall Assessment and Fall Follow Up indicated they were completed due to the resident having a fall on 9/23/24.</p> <p>Review of Resident R50's Neuro Check Eval dated 9/23/24, indicated only six neurological checks were completed out of 16 opportunities.</p> <p>During an interview on 10/31/24, at 10:21 a.m. the Director of Nursing confirmed that the facility failed to timely and accurately complete the post-fall documentation for Resident R50's falls on 9/16/24, and 9/23/24, and failed to complete neurological assessments per facility policy after Resident R50's falls on 9/16/24, and 9/23/24.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(e)(1) Management.</p> <p>28 Pa. Code: 207.2(a) Administrator's responsibility.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure appropriate treatment and services were provided for residents with an indwelling urinary catheter (a tube inserted in the bladder to drain urine) for three of four residents reviewed (Residents R42, R48, and R107).</p> <p>Findings include:</p> <p>Review of facility policy Catheter Care dated 9/19/23, and last reviewed 10/24/24, indicated catheter care at the bedside is performed to promote cleanliness and dignity and is performed by the nursing staff twice daily for residents who have an indwelling catheter. Check that collection bag is not on the floor and is draining properly and secured allowing for no reflux of urine back to the bladder.</p> <p>Review of the clinical record indicated Resident R42 was admitted to the facility on [DATE].</p> <p>Review of Resident R42's Minimum Data Set (MDS- a periodic assessment of care needs) dated 10/15/24, indicated the diagnosis of anemia (low iron in the blood), cerebral palsy (movement disorder), and benign prostatic hyperplasia (BPH-enlargement of the prostate gland)</p> <p>Review of R42 physician order dated 10/8/24, indicated the resident has a foley catheter (flexible tube that drains urine from the bladder through the urethra) The order failed to include the amount of fluid needed to insert for balloon inflation/securement (the balloon keeps catheter in the bladder) or a diagnosis for the foley catheter.</p> <p>During an interview completed on 10/31/24 at 10:19 a.m. Registered Nurse (RN) Employee E3 confirmed the order did not include the amount of fluid needed for balloon inflation/securement or a diagnosis for the foley catheter and the facility failed to ensure appropriate treatment and services were provided for a resident with a foley catheter (Resident R42)</p> <p>Review of the clinical record indicated Resident R48 was admitted to the facility on [DATE].</p> <p>Review of Resident R48's MDS dated [DATE], indicated diagnoses of neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination), and quadriplegia (paralysis of all four limbs).</p> <p>Review of a physician order dated 9/27/24, indicated the resident has a suprapubic catheter (a catheter inserted into the bladder via an incision in the lower abdomen) for neuromuscular dysfunction of the bladder.</p> <p>Review of a physician order dated 7/23/24, indicated to flush suprapubic catheter daily with 60 milliliters of sterile water or normal saline solution in the afternoon.</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 an observation on 10/27/24, at 10:22 a.m. Resident R48's catheter collection bag was observed lying on the floor on the right side of the resident's bed with no dignity cover present. During this same observation, an irrigation syringe used to flush Resident R48's catheter and a bottle of sterile water were on Resident R48's bedside dresser. Both the syringe and bottle of sterile water were open and neither had an open date present.</p> <p>During an interview on 10/27/24, at 11:05 a.m. RN Employee E2 confirmed Resident R48's catheter collection bag was on the floor with no dignity cover and the irrigation syringe and bottle of sterile water were open with no open date present.</p> <p>During an interview on 10/27/24, at 11:05 a.m. RN Employee E2 confirmed that the facility failed to ensure appropriate indwelling urinary catheter treatments and services were provided for Resident R48 as required.</p> <p>Review of the clinical record revealed that Resident R107 was admitted to the facility on [DATE].</p> <p>Review of Resident 107's MDS dated [DATE], indicated diagnoses of high blood pressure, intracerebral hemorrhage (when a ruptured blood vessel causes bleeding inside the brain), and dysphagia (difficulty swallowing).</p> <p>Review of a physician's order dated 10/26/24, indicated that Resident R107 has a Foley catheter (a flexible tube that drains urine from the bladder into a collection bag) for a neurogenic bladder.</p> <p>During an observation on 10/27/24, at 11:49 a.m. Resident R107 was observed resting in bed with no dignity cover on her urine collection bag.</p> <p>During an interview on 10/27/24, at 12:02 p.m. RN Employee E18 confirmed that the facility failed to ensure appropriate indwelling urinary catheter treatments and service were provided for Resident R107 as required.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.29(a)(c)(d)(j) Resident rights.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49469</p> <p>Based on clinical record review, observations, and staff interview, it was determined the facility failed to provide to provide appropriate care and services to residents receiving tube feedings for one of two residents reviewed (Residents R85).</p> <p>Findings Include:</p> <p>A review of the facility policy Medication Administered by Enteral Tube (surgically placed device through an artificial opening in the abdominal wall) dated 10/24/24, indicates this policy addresses guidance for the clinical administration of medications through a G-tube (surgically placed device used to give direct access to the stomach). Equipment needed but no inclusive to 60cc piston syringe, the syringe is dated upon opening and changed daily.</p> <p>Review of the clinical record indicated Resident R85 was admitted to the facility on [DATE].</p> <p>Review of Resident R85's Minimum Data Set (MDS- a periodic assessment of care needs) dated 10/11/24, indicated the diagnosis of hypertension (high blood pressure), diabetes (high sugar in the blood), and dysphagia (difficulty swallowing)</p> <p>Review of resident R85's physician orders dated 4/11/24, indicate enteral feed order one time a day at 10:00 a.m. clear volume fed in the last 24 hours on the pump. Confirm volume to be fed at 1200ml and then turn on.</p> <p>Review of Resident 85's care plan with revision dated 10/24/23, indicates Resident R85 requires a tube feeding due to dysphagia, administer flushes per MD order.</p> <p>During an observation on 10/27/24, at 9:43 a 60cc syringe was sitting in an opened package on the dresser inside of a cup, the syringe failed to be labeled with a date or time.</p> <p>During an interview completed on 10/27/24, at 9:43 a.m. Registered Nurse (RN) Employee E6 confirmed the flush syringe did not have the date opened on it as required and stated I just used it this morning and I didn't put the date on it because I didn't have a marker and confirmed that the facility failed to provide appropriate care and services to residents receiving tube feedings for one of two residents reviewed (Residents R85).</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 211.10(c) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1) 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785</b></p> <p>Based on review of facility policy, clinical records, observations and staff interviews, it was determined that the facility failed to provide appropriate respiratory care and maintain oxygen equipment for two of two residents (Resident R71 and Resident R113).</p> <p>Findings include:</p> <p>The facility Oxygen therapy: using concentrators policy dated 9/19/23, indicated that a concentrator is a medical device used for oxygen supplementation. A physician's order is required for residents on oxygen concentrators. Filters and machines are to be cleaned weekly.</p> <p>Review of the clinical record indicated Resident R71 was admitted to the facility on [DATE].</p> <p>Review of Resident R71's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/14/24, indicated diagnoses of high blood pressure, anxiety (a feeling of worry, nervousness, or unease), and unsteadiness on feet.</p> <p>Review of a physician order dated 9/25/23, indicated to change oxygen tubing every week and as needed every Saturday night shift.</p> <p>During an observation on 10/27/24, at 9:34 a.m. Resident R71's nasal cannula tubing was dated 9/29 and the humidification bottle (a medical device used to enhance moisture and reduce dryness of supplemental oxygen) was empty with no date present.</p> <p>During an interview on 10/27/24, at 10:10 a.m. Registered Nurse (RN) Employee E1 confirmed Resident R71's nasal cannula tubing was dated 9/29 and the humidification bottle was empty with no date present. During this interview, RN Employee E1 confirmed that the facility failed to provide appropriate respiratory care and maintain oxygen equipment for Resident R71 as required.</p> <p>Review of Resident R113's admission record dated 9/21/24, and readmitted on [DATE].</p> <p>Review of Resident R113's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 10/8/24, indicated that Resident R113 had diagnoses that included acute respiratory failure (the body is not receiving sufficient oxygen), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), history of falling, neuromuscular disfunction of bladder (central nervous system lacks communication for urinary function and urgency). The diagnoses were current upon review.</p> <p>Review of Resident R113's care plan dated 10/2/24, indicated to administer oxygen at ten liters via nasal cannula.</p> <p>Review of Resident R113's physician order dated 10/1/24, indicated to clean Resident R113's oxygen concentrator every seven days or as needed.</p> <p>(continued on next page)</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>Review of Resident R113's physician order dated 10/1/24, indicated to change Resident R113's oxygen tubing and humidifier every seven days or as needed.</p> <p>During observations on 10/27/24, at 9:19 a.m. the following was observed in Resident R113 room:</p> <p>Resident R113 was observed resting in bed. Two concentrators were observed in his room and connected to his oxygen line. Both oxygen concentrators were set to 5 liters of concentrated oxygen. There was no date on the oxygen line and no date on the humidifier water-containers for each oxygen concentrator.</p> <p>During an on 10/27/24, at 9:24 a.m. RN Employee E2 confirmed that the facility failed to provide appropriate respiratory care and maintain oxygen equipment for Resident R113 as required.</p> <p>28 Pa. Code: 201.29(i) Resident Rights.</p> <p>28 Pa. Code 211.10(c)(d) Resident Care Policies.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075</b></p> <p>Based on review of facility policy, personnel records and staff interview it was determined that the facility failed to complete annual performance evaluations for five out of five nurse aide personnel records Nurse Aide (NA) Employee E26, E27, E30, E31, and E33).</p> <p>Findings include:</p> <p>Review of facility Wexford Employee Handbook dated 10/24/24, indicated section 3.5 Job Description and Performance Evaluations states it's important to understand what is in your job description. It forms the basis for the annual performance evaluation that you will receive from your supervisor. You and your supervisor will meet at least once a year to review your job performance.</p> <p>Review of NA Employee E26's personnel record indicated she was hired to the facility on [DATE].</p> <p>Review of NA Employee E27's personnel record indicated she was hired to the facility on [DATE].</p> <p>Review of NA Employee E30's personnel record indicated she was hired to the facility on [DATE].</p> <p>Review of NA Employee E31's personnel record indicated she was hired to the facility on [DATE].</p> <p>Review of NA Employee E33's personnel record indicated she was hired to the facility on [DATE].</p> <p>Review of personnel records did not include an annual performance evaluation based on the date of hire for NA Employee E26, E27, E30, E31, and E33.</p> <p>During an interview on 10/31/24, at 12:05 p.m. Regional Human Resource Employee E12 confirmed that the facility failed to complete annual performance evaluations for five out of five NA personnel records (NA Employee E26, E27, E30, E31, and E33) as required.</p> <p>28 Pa Code: 201.20 (a)(b)(c)(d) Staff development.</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>50075</p> <p>Based on an observation and staff interviews, it was determined that the facility failed to prominently display Nurse Staffing Information for two of five days (10/30/24 and 10/31/24).</p> <p>Findings include:</p> <p>During an observation on 10/31/24, at 11:05 a.m. Receptionist Employee E19 failed to locate the current nurse staffing information at the facility's receptionist desk.</p> <p>During an interview on 10/31/24, at 11:07 a.m. Receptionist Employee E19 confirmed that the facility nurse staffing information was from 10/29/24.</p> <p>During an interview on 10/31/24, at 11:10 a.m. Receptionist Employee E19 stated, I hope that's changed. I guess it's my job to do that, nobody really showed me how to do it</p> <p>During an interview on 10/31/24, at 11:12 a.m. the Nursing Home Administrator confirmed that the facility failed to prominently display Nurse Staffing Information for two of five days (10/30/24 and 10/31/24), as required.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(4) Nursing services</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>50075</p> <p>Based on review of facility policy, observation and staff interview it was determined the facility failed to dispose or reconcile discontinued medication in a timely manner for one of two medication rooms reviewed (Second floor D Wing Medication room).</p> <p>Findings:</p> <p>Review of facility Storage of Medications policy dated 10/24/24, indicated that medications and biologicals are stored safely, securely, and properly, following manufacturer ' s recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications. This includes medication rooms, carts, and medication supplies are locked when they are not attended.</p> <p>Review of facility Returning Medications to the Pharmacy policy dated 10/24/24, indicated unused medication are returned to the provider pharmacy for credit whenever possible. For each medication returned, the medication is scanned in the Return for Credit application available in the pharmacy ' s customer portal. Once all scanning is complete, the medication disposition form should be printed. One copy should be retained by the facility and the second copy should be placed with the medication for return.</p> <p>During a medication room review on 10/28/24, at 12:40 p.m. four blister pack of medications was observed in an opened tote in the medication room, which was unlocked. The medications observed were:</p> <ul style="list-style-type: none"> <li>- Zolofit (used for depression) 100 mg - 13 pills.</li> <li>- Warfarin (used to thin blood) 4 mg - 4 pills.</li> <li>- Warfarin 1mg - 12 pills.</li> <li>- Repaglinide (used for high blood sugar) 0.5 mg - 18 pills.</li> </ul> <p>During an interview on 10/28/24, at 12:45 p.m. Licensed Practical Nurse (LPN) Employee E8 stated, We don't have any paperwork to complete prior to sending medications back to the pharmacy. No accountability or disposition of the medication is tracked anywhere that i know. They just put them in the tote.</p> <p>During an interview on 10/28/24, at 2:45 p.m. the Director of Nursing confirmed that the facility failed to dispose or reconcile discontinued medication in a timely manner for one of two medication rooms reviewed (Second floor D Wing Medication room).</p> <p>28 Pa. Code211.12(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50075</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 the facility after the consultant pharmacist recommendations were made for three out of 12 months (November 2023, March 2024, and April 2024).</p> <p>Findings include:</p> <p>The facility Medication Regimen Review policy last reviewed 9/9/23 and 10/24/24, indicated that monthly medication review will be performed by a licensed pharmacist. The pharmacist will report any irregularities to the attending physician, the facilities medical director and director of nursing, and these reports must be acted upon in a timely manner that meets the needs of the residents.</p> <p>Review of Resident R47's admission record indicated he was admitted to the facility on [DATE].</p> <p>Review of Resident R47's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 8/26/24, indicated his diagnoses included high blood pressure, depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time).</p> <p>Review of Resident R47's clinical pharmacy review notes on 10/31/24, at 9:00 indicated the following:</p> <p>November 2023- see notes.</p> <p>December 2023- no recommendations.</p> <p>January 2024 - no recommendations.</p> <p>February 2024- see notes.</p> <p>March 2024- see notes.</p> <p>April 2024- see notes.</p> <p>May 2024- no recommendations.</p> <p>June 2024 - no recommendations.</p> <p>July 2024- no recommendations.</p> <p>August 2024- no recommendations.</p> <p>September 2024- no 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 - Few</p>	<p>October 2024- no recommendations.</p> <p>During an interview on 10/31/24, at 10:15 a.m. the Director of Nursing (DON) stated I could only find February 2024 pharmacy review and failed to produce November 2023, March 2024, and April 2024 pharmacy recommendations that were made.</p> <p>During an interview on 10/31/24, at 10:19 a.m. the DON confirmed that the facility failed to ensure Medication Regimen Reviews were completed by the facility after the consultant pharmacist recommendations were made for three out of 12 months (November 2023, March 2024, and April 2024).</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code 211.5(f) Clinical records.</p> <p>28 Pa. Code 211.9 (k) Pharmacy services.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49469</p> <p>Based on facility policy, clinical record review, and staff interview it was determined the facility failed to identify a diagnosed specific condition for treatment for one of three residents receiving psychotropic medication reviewed (Resident R93)</p> <p>Findings Include:</p> <p>Review of facility policy Resident Rights dated 9/19/23, last reviewed 10/24/24, indicated to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the resident.</p> <p>Review of the admission record indicated that Resident R93 was admitted to the facility on [DATE].</p> <p>Review of Resident R93's care plan revised on 8/27/24, indicated resident R93 uses anti-psychotic medication due to behaviors: verbal outburst, violently shoving items or throwing items, tearful. Observe for side effects of anti-psychotic medications.</p> <p>Review of Resident R93's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/7/24, indicated the diagnoses of hypertension (high blood pressure), viral hepatitis (inflammation of liver due to a viral infection), and anxiety disorder. Section N - Medications, N0415A indicated that Resident R93 was taking, and indication noted for use of Antipsychotic medication.</p> <p>Review of Resident R93's physician orders dated 10/12/24, indicated trazadone 50mg give 1/2 tablet (medication used to treat depression, anxiety and insomnia) at bedtime for mood. The physician orders for antipsychotic medication failed to identify a diagnosed specific condition for treatment.</p> <p>Review of physician order dated 10/16/24, indicated risperdal 1mg (medication used to improve mood, thoughts, and behaviors) every morning and bedtime for mood. The physician orders for antipsychotic medication failed to identify a diagnosed specific condition for treatment.</p> <p>During an interview on 10/30/24, at 1:28 p.m. Registered Nurse (RN) Employee E17 confirmed the facility failed to identify a diagnosed specific condition for treatment and stated it should say like disorder for one of three residents receiving psychotropic medication reviewed (Resident R93).</p> <p>28 Pa Code 211.5(f) Medical records</p> <p>28 Pa code 211.10(c) Resident care policies</p> <p>28 Pa. 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27424</b></p> <p>Based on review of facility policy, clinical record review and staff interview it was determined that the facility failed to make certain that residents are free from significant medication errors for two of eight residents (Resident R73 and R173).</p> <p>Findings include:</p> <p>Review of facility policy Missed Medication/Medication Error dated 10/24/24, indicated the following: Medication error/incident - any physician/provider prescribed medication that is not administered to the resident as prescribed regardless of the category or the reason for not providing the medication.</p> <p>Review of manufactures of guidelines for Trulicity (a type 2 diabetes medication that helps your body release own insulin - given weekly) indicated: Recommendations regarding missed dose - If a dose is missed, instruct patients to administer the dose as soon as possible if there are at least 3 days (72 hours) until the next scheduled dose.</p> <p>Review of the clinical record indicated Resident R73 was admitted to the facility on [DATE].</p> <p>Review of Resident R73 MDS assessment (Minimum Data Set - a periodic assessment of resident care needs) dated 5/22/24, indicated the diagnosis of epilepsy/seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), psychotic disorder (a mental disorder characterized by a disconnection from reality) and mastocytosis (a rare disorder characterized by abnormal accumulation and activation of mast cells in the skin, bone marrow and internal organ).</p> <p>Review of Resident R73 clinical record indicated the following:</p> <p>10/29/24 Cromolyn Sodium (a medication used to prevent the release of substances in the body that cause inflammation) Oral Concentrate MG (milligrams)/5ML (milliliters) Give 15 ml by mouth four times a day for mastocytosis: medication on order, will administer once available - this was documented at 22:45, 17:35, 13:48, and 8:06.</p> <p>10/28/24 Cromolyn Sodium Oral Concentrate MG/5ML Give 15ml by mouth four times a day for mastocytosis - Med not available in house.</p> <p>10/23/24 Cromolyn Sodium Oral Concentrate MG/5ML Give 15ml by mouth four times a day for mastocytosis - request for refill sent ot pharmacy waiting for supply from the pharmacy.</p> <p>10/16/24 Cromolyn Sodium Nasal Aerosol Solution 5.2 MG/ACT 1 spray in each nostril four times a day for mastocytosis 12:07 - Meds not available.</p> <p>During an interview on 10/29/24, at 9:27 a.m. Resident R73 said that she/he has missed medications doesn't feel as well as when she/he gets medications as ordered.</p> <p>Resident R173 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R173 admit sheet indicated diagnosis of type II Diabetes Mellitus (chronic disease that occurs when the body doesn't use insulin properly, resulting in high blood sugar levels), and end stage renal dependence (a permanent condition that occurs when the kidneys are no longer able to function).</p> <p>Review of clinical progress notes dated 10/19/24, indicated Trulicity Subcutaneous Solution Pen-injector 0.75MG/0.5ML Inject .75mg subcutaneously one time a week every Saturday for DM (diabetes mellitus) - medication not available in house, called Pharmacy script syringe to be delivered soon as possible.</p> <p>Review of Resident R173 clinical record failed to show where medication was given.</p> <p>Review of Resident R173 record failed to indicate the physician was notified.</p> <p>During an interview on 10/31/24, at 2:22 p.m. Director of Nursing confirmed that Resident R73 and Resident R173 had missed ordered medication and that the facility failed to get the medication to the residents as ordered and this led to the significant medication error.</p> <p>28 Pa. Code 211.3(a)(b)(c)(d)e(1)(2)(3)(4) Verbal and telephone orders.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</b></p> <p>Based on review of facility policy, observation and staff interview, it was determined that the facility failed to make certain that refrigerated medications are stored at proper temperatures for one of four medication rooms (Third Floor Medication Room), failed to store medications properly and securely in medication carts, failed to secure treatment carts on two out of five treatment carts (Second Floor C1-Nursing unit, and D Unit Treatment carts), failed to ensure a medication room was properly locked (Second Floor D Wing Medication Room), failed to properly store medical supplies and biologicals in one of two medication rooms (Second Floor D Wing Medication Room), failed to store treatments for residents properly to prevent cross contamination for three of four medication carts (First floor RP Medication cart and Second Floor D Wing Medication cart, Third floor East medication cart), failed to store all biologicals in a safe, secure manner for one of three residents (Resident R104) failed to label open medications with a date on one of two medication carts (Third Floor East Wing cart) and in one of four medication rooms (Third Floor medication refrigerator).</p> <p>Findings include:</p> <p>Review of facility Storage of Medications policy dated 10/24/24, indicated that medications and biologicals are stored safely, securely, and properly, following manufacturer ' s recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications. This includes medication rooms, carts, and medication supplies are locked when they are not attended. Orally administered medications are stored separately from externally used medications and treatments. When the original seal of manufacturer ' s container or vial is initially broken, the container or vial will be dated. The nurse shall place a date opened sticker on the medication and the expiration date will be 30 days from opening. Medications must be poured just prior to administering, prepare one resident's medication at a time.</p> <p>Review of the facility policy Medication administration dated 9/19/23, last reviewed on 10/24/24 indicated the facility should maintain a temperature log in the storage area to record temperatures at least once a day.</p> <p>Review of Tuberculin (TB) (a solution that is administered as an aide in the diagnosis of tuberculosis- a lung infection) manufactures guidelines on 10/31/24, at 2:04 p.m. indicated vials in use more than 30 days should be discarded due to losing the effect of the medication.</p> <p>During a tour of the C1 unit on 10/27/24, at 9:05 a.m. two treatment carts were observed outside of room [ROOM NUMBER]. Both treatment carts were observed unlocked.</p> <p>During an interview on 10/27/24, at 9:06 a.m. Registered Nurse (RN) Employee E15 agreed that the treatment carts were both unlocked and confirmed that the facility failed to secure treatment carts on the C1 nursing unit as required.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 10/28/24, at 9:37 a.m. on the Second Floor D Unit, the Employee Breakroom door was propped open and a Treatment Cart containing medications was found to be unlocked, and inside the Employee Breakroom.</p> <p>During an interview on 10/28/24, at 9:47 a.m. Interim Unit Manager Employee E25 confirmed that the facility failed to properly secure a medication cart while not in use on the Second Floor D Unit.</p> <p>During a tour of Second Floor D Wing unit on 10/28/24, at 12:40 p.m. the medication room was propped open with a garbage can and was not locked.</p> <p>During an observation on 10/28/24, at 12:42 p.m. Licensed Practical Nurse (LPN) Employee E8 asked someone to pull the garbage can out of the doorway because The door shouldn't be open. A resident could get in there.</p> <p>During an interview on 10/28/24, at 12:44 p.m. LPN Employee E8 confirmed the medication room was not properly locked (Second Floor D Wing Medication Room).</p> <p>During an observation in Second Floor D Wing Mediation Room on 10/28/24, at 12:45 p.m. a vial of TB solution was stored in the medication storage refrigerator, however failed to have a date of which it was opened and failed to have an expiration date on it.</p> <p>During an interview on 10/28/24, at 12:50 p.m. LPN Employee E8 confirmed that there was no open or expiration date on the vial of TB solution.</p> <p>During a medication cart review on 10/29/24, at 2:04 p.m. it was observed that there were multiple used tubes of treatments on the medication cart. Items observed were:</p> <ul style="list-style-type: none"> <li>- Metronidazole (a cream used for wound care of a cancer lesion)</li> <li>- Diclofenac (a cream used for pain)- four tubes for four different residents.</li> </ul> <p>During an interview on 10/29/24, at 2:33 p.m. LPN Employee E4 confirmed that the above would be considered treatments and should be on the treatment cart.</p> <p>During a medication cart review on 10/30/24, at 8:53 a.m. it was observed that there were two tubes of treatments on the medication cart. Items observed were:</p> <ul style="list-style-type: none"> <li>- Triamcinolone (a cream used for various sin conditions)</li> <li>- Diclofenac - did not contain residents' information.</li> </ul> <p>During an interview on 10/30/24, at 9:58 a.m. LPN Employee E5 confirmed that the above would be considered treatments and should be on the treatment cart.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/30/24, at 2:35 p.m. the Director of Nursing confirmed that the facility failed to ensure a medication room was properly locked (Second Floor D Wing Medication Room), failed to properly store medical supplies and biologicals in one of two medication rooms (Second Floor D Wing Medication Room), and failed to store treatments for residents properly to prevent cross contamination for two of four medication carts ( First floor RP Medication cart and Second Floor D Wing Medication cart).</p> <p>During an observation on 10/27/24, at 10:18 a.m. a white jar labeled nystatin/Silvadene cream (medication applied to the skin used to treat fungal infections) was observed on Resident R104's nightstand.</p> <p>During an interview on 10/27/24, at 10:19 a.m. Licensed Practical Nurse (LPN) Employee E6 stated I can't justify why it's in there removed the white jar from nightstand and confirmed the facility failed to store biologicals in a safe, secure, and orderly manner for one of three residents (Resident R93).</p> <p>During a medication cart review on 10/28/24, at 09:38 a.m. the following was observed on the third-floor East wing medication cart:</p> <p>Top drawer:</p> <p>Medication cup labeled 304 A containing three brown capsules.</p> <p>Medication cup labeled 304 B containing one pink and one white pill.</p> <p>Medication cup labeled 312 A containing a crushed white substance.</p> <p>Medication cup labeled 312 B containing one yellow capsule, one white pill and one pink pill.</p> <p>Medication cup labeled 313A containing one red capsule, one white oblong pill, one green and white capsule.</p> <p>Medication cup labeled 313B containing one blue pill, one white pill, 1/2 of a white pill, two yellow oval shaped pills, one brown pill, two pink pills and one yellow pill.</p> <p>One Novolin Insulin Flex Pen drawn up at 16 units.</p> <p>One Lantus Insulin Pen drawn up at 15 units.</p> <p>One Fiasp -Aspart Insulin Pen drawn up at 6 units.</p> <p>Bottom Drawer:</p> <p>One bottle Geri -tussin house stock not labeled with date opened.</p> <p>One bottle lactulose not labeled with date opened.</p> <p>One bottle guaiasorb DM not labeled with date opened.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>One bottle nystatin liquid not labeled with date opened.</p> <p>One tube of diclofenac gel.</p> <p>During an interview completed on 10/28/24 at 9:38 a.m. Registered Nurse (RN) Employee E11 confirmed the above observations and that the facility failed to properly secure prepared medications, label open medications and properly store biologicals in one of eight medication carts (third floor East wing cart).</p> <p>During an observation and interview on 10/27/24, at 12:19 p.m. of the third-floor medication room the following was discovered:</p> <p>The full-size medication refrigerator temperature log was blank for the following dates: 10/14/24, 10/17/24, 10/18/24 ,10/21/24 ,10/22/24, and 10/23/24.</p> <p>One vial containing Tuberculin not labeled with date opened.</p> <p>The smaller narcotic refrigerator temperature log was blank for the following dates: 10/14/24, 10/17/24, 10/18/24 ,10/21/24 ,10/22/24 ,10/23/24.</p> <p>During an interview completed on 10/27/24, at 12:19 p.m. RN Employee E6 confirmed the above observations and that the facility failed to label open medications with a date in one of four medication rooms (Third Floor medication refrigerator) and failed to monitor refrigerator temperatures in one of four medication rooms. (Third Floor medication room).</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(1) Nursing Services.</p>

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27424</b></p> <p>Based on review of facility policy, resident clinical records, and resident and staff interviews, it was determined that the facility failed to provide routine and emergency dental services for one of two residents (Resident R27).</p> <p>Findings include:</p> <p>The facility Dental services policy dated 9/19/23, indicated that the facility will assist the resident in obtaining routine and 24-hour emergency dental services.</p> <p>Review of Resident R27's admission record indicated he was originally admitted on [DATE], and readmitted on [DATE].</p> <p>Review of Resident R27's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 6/18/24, indicated that he had diagnoses that included diabetes (a metabolic disorder impacting organ function related to glucose levels in the human body), peripheral vascular disease (PVD- a narrowing of the blood vessels in the legs), hypertensive heart disease (a condition characterized by long term heart conditions and high blood pressure), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), and spinal stenosis (a narrowing of the spaces within the spine, which causes pain and weakness). The diagnoses were current upon review.</p> <p>Review of Resident R27's care plan dated 6/26/24, indicated to provide oral hygiene.</p> <p>Review of Resident R27's clinical record and consultation visits did not include routine dental services since his admission on 6/11/24.</p> <p>During an interview on 10/27/24, at 1:10 p.m. Resident R27 stated the following: I never had my beard trimmed. There is no barber in this place. No podiatrists either. I never saw a dentist; he was here last week and I need two teeth to come out.</p> <p>During an interview on 10/30/24, at 8:59 a.m. Medical records/Ancillary services coordinator Employee E14 stated: I coordinate dental, vision, and hearing. Resident R27 is not on the list. I have emailed them multiple times. Resident R27 has not been seen for dental. I will have to look at the vision.</p> <p>During an interview on 10/30/24, at 1:52 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to provide routine dental services to Resident R27 as required.</p> <p>28 Pa Code 211.15(a) Dental services</p>		

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<p>F 0805</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 prepared in a form designed to meet individual needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46167</p> <p>Based on facility policy, observation, and staff interviews, it was determined that the facility failed to provide food in a form to meet individuals' needs in one of two residents ordered an NPO (nothing by mouth) diet.</p> <p>Findings include:</p> <p>Review of the facility policy Resident Rights last reviewed 10/24/24, and previously reviewed 9/9/23, indicated that the facility will provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety of residents, visitors, and employees is a top priority of care.</p> <p>Review of the clinical record revealed that Resident R107 was admitted to the facility on [DATE].</p> <p>Review of Resident 107's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 10/7/24, indicated diagnoses of high blood pressure, Intracerebral hemorrhage (when a ruptured blood vessel causes bleeding inside the brain), and dysphagia (difficulty swallowing). Section K0520 indicated that Resident 107 received nutrition through a feeding tube while she was a resident.</p> <p>Review of Resident R107's physician's orders on 10/27/24, indicated that resident was ordered an NPO diet on 10/25/24.</p> <p>During an observation on 10/27/24, at 11:49 a.m. Resident R107 was observed resting in bed with a large Styrofoam cup full of ice water marked Oral Care, and another large Styrofoam cup full of water marked G-tube (a flexible tube that is surgically inserted into the stomach to provide nutrition, hydration or medication) flush on her bedside table.</p> <p>During an interview on 10/27/24, at 12:02 p.m. Registered Nurse (RN) Employee E18 confirmed that Resident R107 was not allowed to drink anything by mouth and that water was left at her bedside, however RN Employee E18 felt that it was allowed Since I marked the cups.</p> <p>During an interview on 10/27/24, at 12:52 p.m. the Director of Nursing (DON) confirmed that a resident that was NPO should not be left any fluids at bedside in the event that the resident, staff, visitors, or other residents could provide the resident with a drink, and that the facility failed to ensure that Resident R107's diet order was enforced as NPO as ordered.</p> <p>28 Pa. Code: 211.6(d) Dietary services.</p>		

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NAME OF PROVIDER OR SUPPLIER  Wexford Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  9850 Old Perry Highway Wexford, PA 15090	
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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>46167</p> <p>Based on a review of facility policies, observations and staff interviews it was determined that the facility failed to properly label and date food products in the Main Kitchen (Main Kitchen) and failed to properly label and date food in one of two nursing unit pantries (Third Floor Unit Pantry) which created the potential for food borne illness.</p> <p>Findings Include:</p> <p>Review of the facility policy Food Storage: Cold Foods last reviewed 10/24/24, and previously reviewed 9/9/23, indicated that all foods will be wrapped or stored in covered containers, labeled, and dated, and arranged in a manner to prevent cross contamination.</p> <p>During an observation and interview in the Main Kitchen walk-in freezer, on 10/27/24, at 9:30 a.m., an open bag of chicken breast was found to be unsealed, unlabeled and undated, and an open package of ravioli was found to be opened, unlabeled, and undated. Assistant Food Service Supervisor Employee E16 confirmed that the facility failed to properly store, label, and date opened food packages to prevent foodborne illness.</p> <p>During an observation on 10/27/24, at 12:30 p.m. the third-floor unit pantry refrigerator contained:</p> <p>Two containers of vanilla reduced sugar Med pass 2.0 not labeled with date opened.</p> <p>One container of thickened lemon water not labeled with date opened.</p> <p>One container of Panera broccoli cheddar soup not labeled with name or date opened.</p> <p>One box of cheddar biscuits in the freezer not labeled with name or date opened.</p> <p>During an interview completed on 10/27/24, at 12:34 p.m. Licensed Practical Nurse (LPN) Employee E6 confirmed the above observation and that the facility failed to properly label and date food in one of two nursing unit pantries (Third Floor Unit Pantry) which created the potential for food borne illness.</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 211.6c Dietary services.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>27424</p> <p>Based on review of facility documentation and staff interview it was determined that the facility failed to maintain and implement an effective Quality Assurance and performance improvement program that focuses on outcome by failing to implement a QAPI for 11 previously cited citations.</p> <p>Findings include:</p> <p>Review of Plan of Correction from Full Health Survey ending 10/27/23, indicated the following citations:</p> <p>F550</p> <p>F565</p> <p>F585</p> <p>F600</p> <p>F677</p> <p>F684</p> <p>F686</p> <p>F689</p> <p>F693</p> <p>F760</p> <p>F880</p> <p>Facility indicated that the above citations: results of the audits would be forwarded to the facility QAPI committee for further review and recommendation until substantial compliance is maintained.</p> <p>During an interview on 10/31/24, at 2:51 p.m. Nursing Home Administrator confirmed that the facility had multiple repeat deficiencies and failed to maintain and implement an effective QAPI program that focuses on outcome.</p> <p>28 Pa. Code 201.14(a)Responsibility of licensee.</p> <p>28. Pa. Code 201.18(a)(b)(3)e(1)(3)(4)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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785</b></p> <p>Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly monitor resident's personal refrigerators to ensure that food is properly stored and maintained for four of four residents (Resident R7, R47, R77, and R101) failed to maintain proper infection control practices related to care of indwelling urinary catheters (tube inserted in the bladder to drain urine) for two of three residents reviewed (Residents R48 and R113) and failed to provide a safe and sanitary environment to help prevent the potential for cross contamination for one of two medication rooms (Third Floor Medication Room).</p> <p>Findings include:</p> <p>Review of facility policy Storage of Resident Food dated [DATE], indicated it is the policy of the facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Residents have the option of bringing food into the facility or have family or friends bring into the facility as long as safe storage guidelines are followed to protect the resident. The facility recognizes and supports resident's need and right to bring in food from outside sources but still maintain safety and sanitary conditions for storage and consumption. Residents must agree to allow staff to monitor and log the refrigerator temperatures and expiration of food items.</p> <p>Review of facility policy Catheter Care dated [DATE], and last reviewed [DATE], indicated to check that collection bag is not on the floor and is draining properly and secured allowing for no reflux of urine back to the bladder.</p> <p>Review if the facility policy Storage of Medications dated [DATE], and last reviewed [DATE], indicated medications and biologicals are stored safely, securely, and properly. Refrigerated medications are kept in closed and labeled containers with internal and external medications separated from each other.</p> <p>Review of the facility policy Infection Prevention Program: dated [DATE], and last reviewed [DATE], indicates it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Residents have a right to reside in a safe environment that promotes health and reduces the risk of acquiring infections.</p> <p>During an observation on [DATE], at 9:30 a.m. Resident R47 had a small personal refrigerator on his bedside nightstand.</p> <p>During an observation on [DATE], at 10:40 a.m. Resident R7 had a small, personal refrigerator on her bedside nightstand which contained two plastic bowls with no date or labels, and no temperature log that included daily monitoring for Resident R7's personal refrigerator.</p> <p>During an observation on [DATE], at 2:03 p.m. the contents inside Resident R101's refrigerator included two frozen dinners, condiments such as mayonnaise, ketchup, pickles, wrapped food in aluminum foil with no dates, two personal bowls with no dates, and a fast-food bag with sandwiches in it not dated.</p> <p>(continued on next page)</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>During an observation on [DATE], at 2:05 p.m. there was no temperature log that included daily monitoring for Resident R47's personal refrigerator.</p> <p>During an observation on [DATE], at 10:10 a.m. Resident R101 had a small personal refrigerator on her bedside nightstand.</p> <p>During an observation on [DATE], at 2:18 p.m. the contents inside Resident R47's refrigerator included, 14 yogurt, four yogurt in freezer, four small containers of milk (one expired [DATE]), blueberries, grapes, and an orange.</p> <p>During an observation on [DATE], at 2:20 p.m. there was no thermometer inside, and no temperature log that included daily monitoring for Resident R101's personal refrigerator.</p> <p>During an interview on [DATE], at 2:30 p.m. Licensed Practical Nurse (LPN) Employee E6 confirmed that the facility failed to properly monitor resident's personal refrigerators to ensure that food is properly stored and maintained for Residents R47 and R101.</p> <p>During an observation and interview completed on [DATE], at 10:01 a.m. Resident R77 was noted to have a personal refrigerator in his room. Resident R77 stated my wife brings me in food, and my boost. No refrigerator log was noted in the room.</p> <p>During an interview and observation on [DATE] at 1:05 p.m. LPN Employee E6 opened the refrigerator and pulled out a thermometer. LPN Employee E6 stated, There is a thermometer, I can't answer if they check the temperatures, and confirmed there was not a temperature log that included daily monitoring for Resident R77's personal refrigerator.</p> <p>During an interview on [DATE], at 10:28 a.m. the Director of Nursing confirmed that the facility failed to ensure that expiration of food items and refrigeration temperatures were monitored for Resident R7.</p> <p>Review of the clinical record indicated Resident R48 was admitted to the facility on [DATE].</p> <p>Review of Resident R48's MDS dated [DATE], indicated diagnoses of neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination), and quadriplegia (paralysis of all four limbs).</p> <p>Review of a physician order dated [DATE], indicated the resident has a suprapubic catheter for neuromuscular dysfunction of the bladder.</p> <p>During an observation on [DATE], at 10:22 a.m. Resident R48's catheter collection bag was observed lying on the floor on the right side of the resident's bed with no dignity cover present.</p> <p>During an interview on [DATE], at 11:05 a.m. Registered Nurse (RN) Employee E2 confirmed Resident R48's catheter collection bag was on the floor with no dignity cover.</p> <p>During an interview on [DATE], at 11:05 a.m. RN Employee E2 confirmed that the facility failed to maintain proper infection control practices related to Resident R48's indwelling urinary catheter as required.</p> <p>(continued on next page)</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>Review of Resident R113's admission record dated [DATE], and readmitted on [DATE].</p> <p>Review of Resident R113's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated [DATE], indicated that Resident R113 had diagnoses that included acute respiratory failure (the body is not receiving sufficient oxygen), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), history of falling, neuromuscular disfunction of bladder (central nervous system lacks communication for urinary function and urgency). The diagnoses were current upon review.</p> <p>Review of Resident R113's physician order dated [DATE], indicated to provide indwelling catheter, change indwelling catheter and bag as needed.</p> <p>During observations on [DATE], at 9:19 a.m. the following was observed in Resident R113 room:</p> <p>Resident R113 was observed resting in bed. Resident R113's was observed with a clear line leading to a catheter bag. The catheter bag was observed on the floor with clear fluid in the bag.</p> <p>During an interview on [DATE], at 9:24 a.m. RN Employee E2 confirmed that the facility failed to maintain infection control with the use of a catheter for Resident R113.</p> <p>During an observation on [DATE], at 12:19 p.m. the Third Floor Medication Room freezer contained:</p> <p>16 white ice packs</p> <p>two soft blue cloth comfort ice packs</p> <p>three blue ice packs</p> <p>During an interview completed on [DATE], at 12:25 p.m. LPN Employee E6 removed all the ice packs and stated, I have never seen these before (the blue soft ones) these blue ones look like the ones they use for knee surgeries there are no names on them, and confirmed the facility failed to provide a safe and sanitary environment to help prevent the potential for cross contamination for one of two medication rooms (Third Floor Medication Room).</p> <p>28 Pa. code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b) (1) (e) (1) Management.</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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27424</p> <p>Based on observations and staff interview it was determined that the facility failed to maintain essential equipment heating units for three rooms on the second floor (238, 239, and 251).</p> <p>Findings include:</p> <p>During observations on the second floor the following was observed:</p> <p>10/27/24: 1:01 p.m. rooms [ROOM NUMBERS] heater removed from wall area open to outside.</p> <p>10/27/24: 1:12 p.m. room [ROOM NUMBER] heater removed from wall area open to outside.</p> <p>During an interview on 10/27/24, at 1:30 p.m. Nursing Home Administrator (NHA) confirmed that the facility failed pulled the heaters from the above rooms for other rooms in the facility,.</p> <p>During an interview on 10/27/24, at 1:30 p.m. NHA confirmed that the facility failed to maintain essential equipment with heating units being removed from 3 resident rooms, for other rooms that heating units weren't working.</p> <p>28 Pa. Code 207.2 (a)Administrator's responsibility.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>27424</p> <p>Based on review of facility documentation, resident and staff interview it was determined that the facility failed to maintain an effective pest control program for two of three floors ( first and second floors).</p> <p>Findings include:</p> <p>During an interview on 10/30/24, at 9:02 a.m. Resident R73 stated that she/he had a mouse in her room in June of 2024.</p> <p>During an interview on 10/30/24, at 11:00 a.m. County Ombudsman confirmed that during a visit with resident R73 they observed mouse droppings around the room of Resident R73.</p> <p>Review of facility documentation resident concerns, showed residents from 2nd floor having multiple concerns regarding seeing mice.</p> <p>During observations on 10/31/24, at 12:10 p.m. Director of Maintenance Employee E36 showed an outside door that has rusted out on the bottom corner of the door where they believe the mice are coming in.</p> <p>During an interview on 10/31/24, at 12:20 p.m. Director of Maintenance Employee E36 confirmed that Resident R73 did have a hole in an outside wall and mouse droppings were in the room. Director of Maintenance Employee E36 confirmed that residents on the second floor did report seeing mice. The last reported mouse sighting was last week on the first floor in a storage room. Director of Maintenance Employee E36 confirmed that the facility failed to maintain ineffective pest control program.</p> <p>28 Pa. Code: 201.14 (a) Responsibility of licensee.</p>