STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395341	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elk Haven Nursing Home	785 Johnsonburg Road Saint Marys, PA 15857

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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 31185 Based on review of facility policy, observations and staff interview, it was determined that the facility failed to provide resident privacy during a wound dressing change for one of 22 residents reviewed (Resident R62). Findings include: The facility policy Privacy / Dignity dated 1/10/24, indicated that Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. Observation of a wound dressing change for Resident R62 on 6/5/24, at 10:45 a.m. revealed that Licensed Practical Nurse (LPN) Employee E2 and LPN Employee E3 changed wound dressings to the resident's right heel and foot while the roommate was awake and watching the procedure. During an interview on 6/5/24, at 11:15 a.m. LPN Employee E3 confirmed that the privacy curtain should have been pulled. During an interview on 6/5/24, at 11:35 a.m. the Director of Nursing confirmed that during a dressing change the privacy curtain should have been pulled. 28 Pa. Code 211.12(d)(1)(2) Nursing services

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to develop and implement a resident centered comprehensive care plan for one of 22 residents reviewed (Resident R58). Findings include: A facility policy entitled, Comprehensive Person-Centered Car Planning dated 1/10/24, indicated that a comprehensive person-centered care plan including necessary and appropriate care, attending physicians ordered, services and accommodation of resident needs and preferences for the resident to attain or maintain the highest practicable physical, mental, and psychological well-being will be established within 21 days of admission. Resident R58's clinical record revealed an admitted [DATE], with diagnoses that included pleural effusion (buildup of fluid between the layers of tissue that line the lungs and chest cavity), arthritis, lower back pain, and restless leg syndrome. Resident R58's clinical record included physician's orders dated: 3/06/24, to give 650 milligrams (mg) of acetaminophen every six hours as needed for pain; 3/14/24, to give 650 mg of acetaminophen at bedtime for pain management; 4/01/24, to give 650 mg three times a day for back pain and 650 mg as needed for back pain once daily; and current physician's orders dated 5/09/24, to give 650 mg of Tylenol three times a day for other low back pain, and give 650 mg of Tylenol every four hours as needed for pain, may have one additional dose four plus hours after nine p.m. Resident R58's clinical record lacked evidence of a comprehensive person-centered care plan for pain. During an interview on 6/05/24, at 10:47 a.m. the Director of Nursing confirmed that Resident R58's clinical record lacked evidence of a comprehensive person-centered care plan for pain management. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, observation, and staff interview, it was determined that the facility failed to maintain proper care of respiratory equipment for one of four residents reviewed for respiratory care (Resident R29). Findings include: Facility policy entitled Use of Oxygen dated 1/10/24, indicated that the facility changes oxygen cannulas (flexible tubing inserted into the nostrils for oxygen delivery) or masks every 30 days. Resident R29's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (lung disease resulting in difficulty breathing and persistent cough), high blood pressure, and diabetes. Resident R29's physician orders dated 4/5/21, indicated to change oxygen tubing on the 15th of each month. Observations on 6/2/24, at 2:08 p.m. and 6/4/24, at 9:00 a.m. revealed that Resident R29's oxygen tubing contained a piece of white tape wrapped around it with a date of 3/15/24. During an interview on 6/4/24, at 9:22 a.m. Licensed Practical Nurse Employee E1 confirmed that the oxygen tubing was dated for 3/15/24, and was not changed monthly as ordered. 28 Pa. Code 211.12(d)(1)(5) Nursing services