STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395342	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopkins Center	8100 Washington Lane Wyncote, PA 19095

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 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** 39344 Based on observations, clinical record review and interviews with staff, it was determined that the facility failed to develop a comprehensive person-centered care plan related to intravenous (IV) therapy for one of three residents reviewed (Resident R1). Findings include: Observation on July 9, 2024, at 9:25 a.m. revealed that Resident R1 had a PICC (peripherally inserted central catheter - a thin soft tube inserted in a vein in the arm with the tip of the tube positioned in a large vein that carries blood to the heart) line in his left upper arm. Review of Resident R1's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated June 27, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including pneumonia (lung inflammation caused by bacterial or viral infection) and septicemia (a life-threatening infection that occurs when bacteria enter the bloodstream). Continued review revealed that the resident received IV medications (intravenous therapy that delivers liquid substances directly into a vein). Review of hospital records for Resident R1 revealed that the resident had a single lumen PICC line inserted into his left upper arm on June 13, 2024. Review of physician orders for Resident R1 revealed an order, dated June 24, 2024, for cefazolin (antibiotic medication) infuse two grams intravenously every eight hours for sepsis until July 23, 2024, administer in 100 milliliters of 0.9% sodium chloride (salt water solution). Review of Resident R1's care plan, dated initiated June 24, 2024, revealed that the resident had an infection related to sepsis. Continued review revealed that there was no documentation available for review at the time of the survey that a care plan had been developed related to the resident's PICC line or need for IV antibiotic infusions. Interview on July 9, 2024, at 2:45 p.m. the Director of Nursing confirmed that there was no documentation available in Resident R1's clinical record available for review at the time of the survey to indicate that a care plan had been developed for his PICC line or IV antibiotic infusions. 28 Pa Code 211.10(d) Resident care policies (continued on next page)

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	28 PA Code 211.12(d)(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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on observations, clinical record review, review of facility policies and interviews with staff, it was determined that the facility failed to administer intravenous (IV) medications in accordance with professional standards of practice for one of three residents reviewed related to IV therapy (Resident R1). Findings include: Review of facility policy, Central Venous Access Device (CVAD) Dressing Change dated June 1, 2021, revealed, Central vascular access devices (CVADs) include: Peripherally inserted central catheter [PICC - a thin soft tube inserted in a vein in the arm with the tip of the tube positioned in a large vein that carries blood to the heart]. Continued review revealed that the length of the external catheter should be measured during dressing changes by measuring from the insertion site to where the catheter meets the hub to assess for line migration and to measure the arm circumference ten centimeters above the antecubital (inside of the elbow) and compare to baseline measurements to assess for blood clots. Observation on July 9, 2024, at 9:25 a.m. revealed that Resident R1 had a PICC line in his left upper arm. Review of Resident R1's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated June 27, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including pneumonia (lung inflammation caused by bacterial or viral infection) and septicemia (a life-threatening infection that occurs when bacteria enter the bloodstream). Continued review revealed that the resident received IV medications (intravenous therapy that delivers liquid substances directly into a vein). Review of hospital records for Resident R1 revealed that the resident had a single lumen PICC line inserted into his left upper arm on June 13, 2024. Review of physician orders for Resident R1 revealed an order, dated June 24, 2024, for cefazolin (antibiotic medication) infuse two grams intravenously every eight hours for sepsis until July 23, 2024, administer in 100 milliliters of 0.9% sodium chloride (salt water solution). Continued review of physician orders for Resident R1 revealed an order, dated June 26, 2024, to change IV catheter site dressing every Friday; indicate external catheter length and upper arm circumference (10 cm above antecubital); and to notify practitioner if external length has changed since last measurement. Review of Medication Administration Records (MARs) for Resident R1 for June and July 2024, revealed that on June 28, 2024, the resident's IV catheter site dressing change was documented as No/See Nurse Note and no measurements were documented for the external catheter length or arm circumference. Continued review revealed that on July 5, 2024, the dressing change was documented as administered, however, no measurements were documented for the external catheter length or arm circumference. (continued on next page)

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes for June 28 and July 5, 2024, revealed that no documentation was entered by nursing staff related to the IV catheter site dressing changes. Interview on July 9, 2024, at 2:45 p.m. the Director of Nursing confirmed that there was no documentation available in Resident R1's clinical record available for review at the time of the survey to indicate if the resident's PICC line was properly assessed and monitored during the IV catheter site dressing changes. 28 PA Code 211.12(d)(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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on review of review of personnel files, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that nursing staff had the specific competencies and skills sets necessary to care for residents' needs related to medication administration and infusion therapy, which resulted in a significant medication error for Resident R1, for two of two personnel files reviewed (Employees E3 and E4). Findings include: Review of the Pennsylvania Nurse Practice Act, 49 Pa Code 21.145(f)(g) Functions of the LPN (licensed practical nurse), revealed, An LPN may perform only the IV therapy functions for which the LPN posses the knowledge, skill and ability to perform in a safe manner. Continued review revealed, Prior to the initiation of IV therapy, an LPN shall: Verify the order and identity of the patient. Further review revealed, An LPN who had met the education and training requirements . may perform the following IV functions . Administration of IV fluids and medications; Observation of the IV insertion site and performance of insertion site care; Performance of maintenance. Maintenance includes dressing changes, IV tubing changes, and saline or heparin flushes. Review of personnel file for Employee E3, graduate nurse, revealed that the employee was hired by the facility on May 22, 2024, as a graduate practical nurse (a graduate nurse has completed a formal education program in a school of nursing but has not yet taken the nurse licensing exam). Review of Employee E3's, graduate nurse, Licensed Nurse Orientation Checklist, dated May 22, 2024, revealed that under the heading Medication Administration was a requirement for Medication Administration Competency Validation - Required; there was no indication that this requirement had been met. Continued review of the Licensed Nurse Orientation Checklist, revealed that under the heading Infusion Therapy were requirements that LPN may perform infusion therapy activities according to state regulations and must successfully complete or show proof of completion of an infusion therapy education program prior to providing infusion services as well as RN [registered nurse] and LPN must demonstrate skills competency prior to administering/managing infusion therapy. Further review of Employee E3's, graduate nurse, personnel file revealed that no documentation was available for review at the time of the survey to indicate if Employee E3, graduate nurse, had any skills competency evaluations that included the specific skill sets that are required for medication administration and IV infusion therapy. Review of personnel file for Employee E4, licensed nurse, revealed that the employee was hired by the facility as an agency LPN. Review of training records for Employee E4, licensed nurse, revealed that the employee had completed computer-based training related to dementia and mechanical lifts. Further review of Employee E4's, licensed nurse, personnel file revealed that no documentation was available for review at the time of the survey to indicate if Employee E4, licensed nurse, had any skills competency evaluations that included the specific skill sets that are required for medication administration and IV infusion therapy. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R1's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated June 27, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including pneumonia (lung inflammation caused by bacterial or viral infection) and septicemia (a life-threatening infection that occurs when bacteria enter the bloodstream). Continued review revealed that the resident received IV medications (intravenous therapy that delivers liquid substances directly into a vein). Review of physician orders for Resident R1 revealed an order, dated June 24, 2024, for cefazolin (antibiotic medication) infuse two grams intravenously every eight hours for sepsis, administer in 100 milliliters of 0.9% sodium chloride (salt water solution). Review of Resident R2's 5-Day Medicare MDS assessment, dated June 24, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including hip fracture, wound infection and MDRO (multidrug-resistant organism - bacteria that are resistant to antibiotics and difficult to treat). Continued review revealed that the resident received IV medications. Review of physician orders for Resident R2 revealed an order, dated June 21, 2024, for cefazolin infuse two grams intravenously every eight hours for infection, administer in 100 milliliters of D5 solution (sugar water solution). Review of facility documentation submitted to the Pennsylvania Department of Health on June 28, 2024, revealed that an IV medication prescribed for Resident R2 was administered to Resident R1. Review of facility documentation revealed a witness statement by Employee E3, graduate nurse, dated June 28, 2024, that stated, On June 26, 2024, I pulled the 4:00 p.m. dose of cefazolin 2 gram in 100cc [milliliter] dose for [Resident R1]. I checked the medication and it did have [Resident R1's] name on it, it was the correct medication and dose. I attempted to prime the bag using the new tubing and pump, I had a lot of air bubbles in the line and when I tried to correct it most of the medication was discarded. I discarded that bag because so much was lost. I went to pull another bag and the nurse with me that day primed it herself and she also showed another nurse how to prime the pump and use the tubing. I took the set up to [Resident R1's] room but he was in therapy so I left it there for his return. When I saw him back in his room I went to attach his IV when he stopped me and said, 'The name on this bag is not me.' I acknowledged that it was not his name on the medication bag, I did say this is the same medication, same dose but I am going to stop it. He responded, 'No its ok as long as it's the same medication you can keep it running.' He then spoke about the food and wanted more variety and double plates with snacks. The medication was infused. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of facility documentation revealed a witness statement by Employee E4, agency licensed nurse, dated June 28, 2024, that stated, I was orienting the nurse. I worked with the nurse on orientation on several occasions. On the day of the incident [Employee E3, graduate nurse], and I both agreed that at this point during orientation he was able to work alone without my supervision. The nurse I was working with asked if I would show her how to prime the new tubing when we hung the next dose. I saw [Employee E3, graduate nurse] grab the next dose and I stopped him to show them how to prime the tubing. I was not aware that he had wasted a bag just prior and he was actually hanging a second bag. After I primed the bag [Resident R1] was not in his room and we left the pole there. We went to do documentation and at some point I said go see if he is back in his room. We had hung the medication earlier that morning without issue. He was gone for awhile so I went to look for him and he was talking to the resident. I called him out of the room and asked what was going on. He made me aware that the patient stated that the name on the medication was incorrect, it belonged to another resident. The nurse told me that he explained to the resident that the medication was the correct med. He explained to resident that he has the right to refuse the medication. Resident stated it was ok to keep infusing. Teaching was provided to fell ow nurse following situation. Interview on July 9, 2024, at 10:09 a.m. Employee E3, graduate nurse, revealed that he was a new nurse, that he was still on orientation and that this was his first job as new nurse. Employee E3, graduate nurse, stated that he was training with Employee E4, agency licensed nurse, and that he had administered Resident R1's morning dose of cefazolin correctly. Employee E3, graduate nurse, stated that he hung the afternoon dose for Resident R1 and confirmed that the medication was prescribed for a different resident (Resident R2). Employee E3, graduate nurse, confirmed that the entire dose was infused. Interview on July 9, 2024, at 12:30 p.m. the Director of Nursing revealed that Employee E3, graduate nurse, was not IV certified and that the facility did not have any evidence that IV infusion education, IV skills competency evaluation or medication administration skills competency evaluation had been completed for the employee. The Licensed Nurse Orientation Checklist for Employee E3, graduate nurse, was reviewed with the Director of Nursing. The Director of Nursing agreed that the orientation checklist did not list any of the specific skills required for medication administration and IV infusion therapy. Continued interview with the Director of Nursing revealed that Employee E4, licensed nurse, was an agency nurse and that the facility did not have the employee's personnel file readily accessible. The Director of Nursing stated that the facility does not perform skills competency evaluations for agency staff and expects the agency to do it. The Director of Nursing confirmed that there was no evidence that Employee E4, licensed nurse, had completed any IV infusion training, what her knowledge, experience or skill set were related to IV infusions or what information was specifically taught to Employee E3, graduate nurse, during his orientation process. There was also no evidence that Employee E4, licensed nurse, had any skills competency evaluations related to medication administration. Further interview, the Director of Nursing was unable to provide any documentation at the time of the survey of the facility's process for evaluating skills competencies for licensed nursing staff related to medication administration and IV infusion therapy. The Director of Nursing was unable to provide any documentation of the facility's infusion therapy education or identify any staff that had completed training and skills competency evaluations for IV infusion therapy. Refer to F760. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 201.19(7) Personnel policies and procedures 28 Pa Code 211.12(d)(2) Nursing services 28 Pa Code 211.12(d)(5) Nursing services

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on review of facility policies, facility documentation, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that residents remained free from significant medication errors for one of five residents reviewed (Resident R1). Findings include: Review of facility policy, General Dose Preparation and Medication Administration dated April 30, 2024, revealed, Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident. Continued review revealed, During medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: Verify resident identification per facility policy (e.g. picture, armband, name). Facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration record. Review of Resident R1's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated June 27, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including pneumonia (lung inflammation caused by bacterial or viral infection) and septicemia (a life-threatening infection that occurs when bacteria enter the bloodstream). Continued review revealed that the resident received IV medications (intravenous therapy that delivers liquid substances directly into a vein). Review of physician orders for Resident R1 revealed an order, dated June 24, 2024, for cefazolin (antibiotic medication) infuse two grams intravenously every eight hours for sepsis, administer in 100 milliliters of 0.9% sodium chloride (salt water solution). Review of Resident R2's 5-Day Medicare MDS assessment, dated June 24, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including hip fracture, wound infection and MDRO (multidrug-resistant organism - bacteria that are resistant to antibiotics and difficult to treat). Continued review revealed that the resident received IV medications. Review of physician orders for Resident R2 revealed an order, dated June 21, 2024, for cefazolin infuse two grams intravenously every eight hours for infection, administer in 100 milliliters of D5 solution (sugar water solution). Review of facility documentation submitted to the Pennsylvania Department of Health on June 28, 2024, revealed that an IV medication prescribed for Resident R2 was administered to Resident R1. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility documentation revealed a witness statement by Employee E3, graduate nurse, dated June 28, 2024, that stated, On June 26, 2024, I pulled the 4:00 p.m. dose of cefazolin 2 gram in 100cc [milliliter] dose for [Resident R1]. I checked the medication and it did have [Resident R1's] name on it, it was the correct medication and dose. I attempted to prime the bag using the new tubing and pump, I had a lot of air bubbles in the line and when I tried to correct it most of the medication was discarded. I discarded that bag because so much was lost. I went to pull another bag and the nurse with me that day primed it herself and she also showed another nurse how to prime the pump and use the tubing. I took the set up to [Resident R1's] room but he was in therapy so I left it there for his return. When I saw him back in his room I went to attach his IV when he stopped me and said, 'The name on this bag is not me.' I acknowledged that it was not his name on the medication bag, I did say this is the same medication, same dose but I am going to stop it. He responded, 'No its ok as long as it's the same medication you can keep it running.' He then spoke about the food and wanted more variety and double plates with snacks. The medication was infused. Continued review of facility documentation revealed a witness statement by Employee E4, agency licensed nurse, dated June 28, 2024, that stated, I was orienting the nurse. I worked with the nurse on orientation on several occasions. On the day of the incident [Employee E3, graduate nurse], and I both agreed that at this point during orientation he was able to work alone without my supervision. The nurse I was working with asked if I would show her how to prime the new tubing when we hung the next dose. I saw [Employee E3, graduate nurse] grab the next dose and I stopped him to show them how to prime the tubing. I was not aware that he had wasted a bag just prior and he was actually hanging a second bag. After I primed the bag [Resident R1] was not in his room and we left the pole there. We went to do documentation and at some point I said go see if he is back in his room. We had hung the medication earlier that morning without issue. He was gone for awhile so I went to look for him and he was talking to the resident. I called him out of the room and asked what was going on. He made me aware that the patient stated that the name on the medication was incorrect, it belonged to another resident. The nurse told me that he explained to the resident that the medication was the correct med. He explained to resident that he has the right to refuse the medication. Resident stated it was ok to keep infusing. Teaching was provided to fell ow nurse following situation. Interview on July 9, 2024, at 10:09 a.m. Employee E3, graduate nurse, revealed that he was a new nurse, that he was still on orientation and that this was his first job as new nurse. Employee E3, graduate nurse, stated that he was training with Employee E4, agency licensed nurse, and that he had administered Resident R1's morning dose of cefazolin correctly. Employee E3, graduate nurse, stated that he hung the afternoon dose for Resident R1 and confirmed that the medication was prescribed for a different resident (Resident R2). Employee E3, graduate nurse, confirmed that the entire dose was infused. Interview on July 9, 2024, at 10:15 a.m. the Director of Nursing confirmed that Employee E3, graduate nurse, incorrectly administered Resident R2's IV medication to Resident R1. The Director of Nursing confirmed that Resident R1 was monitored and had no negative effects from the incorrect medication. The Director of Nursing confirmed that Resident R2 received his dose of cefazolin as prescribed. 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa Code 211.10(d) Resident care policies 28 Pa Code 211.12(d)(1) Nursing services (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.12(d)(5) Nursing services