

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Maple Ridge Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Wyoming Avenue Kingston, PA 18704	

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 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>48276</p> <p>Based on a review of resident council meeting minutes and resident and staff interviews, it was determined that the facility failed to ensure that the facility considered the views and recommendations raised during resident group meetings, including experiences expressed by five residents out of five during a resident group interview (Residents 18, 31, 36, 49, and 86), and failed to ensure that the facility acted upon grievances and concerns raised during resident group meetings for one resident out of the 21 sampled (Resident 22).</p> <p>Findings include:</p> <p>The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.</p> <p>A review of Resident Council meeting minutes dated June 25, 2024, revealed that residents in attendance raised concerns regarding vegetarian food options such as vegetarian hotdogs and vegetarian bacon.</p> <p>A review of the facility's June 2024 grievance log revealed no documentation of the concerns residents raised regarding the resident council meeting on June 25, 2024.</p> <p>A review of Resident Council meeting minutes dated July 23, 2024, revealed no documented evidence of a response to residents' concerns regarding vegetarian food options.</p> <p>During an interview on August 7, 2024, at 9:50 AM, Resident 22, indicated she raised concerns during a resident council meeting on June 25, 2024, that were not addressed or resolved. She indicated that she received no response from the facility individually or at following resident council or food committee meetings.</p> <p>During an interview on August 8, 2024, at approximately 1:00 PM, the Nursing Home Administrator (NHA) was unable to provide documentation that the concerns Resident 22 raised during the resident group meeting regarding her diet preferences were addressed or resolved.</p> <p>A review of Resident Council meeting minutes dated May 23, 2024, revealed the Treasurer's Report section. The area for the amount was blank. The meeting minutes had no documented evidence of resident fund monetary activities or related discussions.</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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident Council meeting minutes dated June 25, 2024, revealed the Treasurer's Report section. The area for the amount indicated a value of \$1186.56. The meeting minutes had no documented evidence of resident fund monetary activities or related discussions.</p> <p>A review of Resident Council meeting minutes dated July 23, 2024, revealed the Treasurer's Report section. The area for amount indicated a value of \$1186.56. The meeting minutes had no documented evidence of resident fund monetary activities or related discussions.</p> <p>During a resident group interview on August 8, 2024, residents in attendance (Residents 18, 31, 36, 49, and 86) were not able to explain why there was a treasurer's report on the monthly resident council meeting minutes. Residents in attendance were unable to recall discussing the resident fund or any decision making regarding the resident fund. The residents indicated that they do not recall staff asking for resident input or considering their views for resident fund activities.</p> <p>During an interview on August 8, 2024, at 1:15 PM, Employee 1, Activities Director, demonstrated financial records she keeps regarding resident fund monetary activities. Employee 1 explained that funds are raised by snack cart purchases made by residents and employees. She also indicated that funds are raised through employee donations. Employee 1 was not able to provide documented evidence of resident involvement, input or recommendations regarding resident fund monetary activities.</p> <p>During an interview on August 8, 2024, at approximately 1:30 PM, the Nursing Home Administrator (NHA) confirmed that it is the facility's responsibility to consider the view of residents during resident group meetings. The NHA was not able to provide documented evidence that residents views and input were discussed regarding resident fund activities.</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 201.29(a) Resident Rights</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on a review of clinical records, select facility policy and investigative reports, and staff interviews, it was determined that the facility failed to ensure that one resident out of 18 sampled (Resident 39) was free from physical abuse, perpetrated by another resident (Resident CR4).</p> <p>Findings include:</p> <p>A review of facility policy titled Abuse of Residents, last reviewed by the facility on May 1, 2024, revealed it is the facility policy that acts of physical abuse directed against residents are absolutely prohibited. The policy indicates that each resident has the right to be free from physical abuse and shall not be subjected to abuse by anyone, including but not limited to staff, other residents, consultants, volunteers, family members, friends, or other individuals. The policy defines physical abuse as including but not limited to hitting, slapping, punching, or kicking.</p> <p>A clinical record review revealed Resident 39 was admitted to the facility on [DATE], with diagnoses that include dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 13, 2024, revealed that Resident 39 is severely cognitively impaired with a BIMS score of 2 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 01-07 indicates severe cognitive impairment).</p> <p>A clinical record review revealed that Resident CR4, was admitted to the facility on [DATE], with diagnoses that include chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and dementia.</p> <p>A review of an annual MDS assessment dated [DATE], revealed that Resident CR4 is cognitively intact with a BIMS score of 14 (a score of 13-15 indicates cognitively intact).</p> <p>A care plan review revealed Resident CR4 has behaviors related to dementia with agitation, makes accusatory statements, and is physically and verbally aggressive toward others initiated on April 14, 2024. Interventions implemented to assist Resident CR4 with these behaviors include approaching the resident in a calm manner to avoid frustration and behavior escalation, giving the resident non-judgmental support, and keeping the resident safe during episodes of behaviors.</p> <p>A progress note dated April 14, 2024, at 6:09 AM indicated that Resident CR4 propelled himself up the hallway in his wheelchair cursing, yelling, and name-calling at staff. The resident became agitated and started throwing a snack tray and chair at staff. Resident CR4 attempted to kick staff.</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>A progress note dated April 15, 2024, at 6:46 AM indicated that Resident CR4 was yelling and cursing at staff.</p> <p>A progress note dated April 15, 2024, at 7:00 AM indicated that Resident CR4 displayed verbally aggressive behavior with staff at midnight the previous shift. The note indicated he was cursing and yelling at staff.</p> <p>A progress note dated April 16, 2024, at 6:32 AM indicated that Resident CR4 was yelling and cursing at staff at the beginning of the shift, but displayed no additional behaviors.</p> <p>A facility incident report dated April 19, 2024, at 12:05 PM indicated that Resident CR4 was observed yelling at Resident 39. Staff attempted to redirect Resident CR4, explaining that Resident 39 did not understand him; however, the redirection was not effective, and Resident CR4 continued yelling.</p> <p>A witness statement dated April 19, 2024, revealed that Employee 3, Nurse Aide (NA), was assisting residents in the dining room, on April 19, 2024, at 12:05 PM when she witnessed Resident CR4 punch and kick Resident 39. Employee 3, NA, indicated that she immediately removed Resident 39 for safety and notified the nurse.</p> <p>A witness statement dated April 19, 2024, revealed that Employee 5, NA, heard his coworker scream for help on April 19, 2024, at 12:05 PM. When he arrived, he witnessed Resident CR4 attempting to throw coffee on Resident 39. Employee 5, NA, indicated that Resident CR4 has been having outbursts and has been verbally abusive to the same resident weeks prior.</p> <p>A progress note dated April 19, 2024, at 12:05 PM indicated that Resident CR4 was screaming and yelling at staff. Staff witnessed Resident CR4 punch Resident 39 in the face and throw a full glass of orange juice at him. The note indicated that Resident CR4 stated, He doesn't belong here. I will beat the living sh** out of him!</p> <p>Resident CR4 refused care and was swinging his fist at staff. The note indicated that Resident CR4 was sent to the community hospital due to combative and aggressive behavior.</p> <p>A progress note dated April 19, 2024, at 12:07 PM indicated that Resident 39 is alert only to himself, does not seem to understand questions, and is not able to verbalize what occurred {in the dining room on on April 19, 2024, at 12:05 PM}. The note indicated that prior to lunch being served, Resident 39 picked up an orange juice that was sitting on a table and started to drink it. Resident CR4 was sitting in the dining room and started yelling at Resident 39, saying, That's my orange juice!</p> <p>Resident CR4 approached Resident 39, picked up another glass of orange juice, and threw it on Resident 39, covering his shirt and lap in juice. Resident 39 did not appear to understand and continued to hold the glass of orange juice. Resident CR4 then punched Resident 39 in the face. Resident 39 was removed from the area for safety.</p> <p>A progress note dated April 19, 2024, at 2:34 PM indicated Resident 39 had no complaints of pain.</p> <p>A progress note dated April 20, 2024, at 5:56 PM indicated that Resident 39 denies any pain or discomfort and neurological checks were within normal limits. The note indicated Resident 39 had no redness, swelling, or erythema noted.</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 August 9, 2024, at approximately 9:30 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that Resident CR4 threw orange juice on Resident 39 and punched him in the face. The NHA and DON confirmed that the facility failed to prevent Resident 39 from abuse perpetrated by Resident CR4. The NHA confirmed that it is the facility's responsibility to ensure residents are not subjected to abuse by anyone, including other residents.</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 201.29(a) Resident rights.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on a review of clinical records, the Resident Assessment Instrument, and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of 21 sampled (Resident 142).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 142 was admitted to the facility on [DATE].</p> <p>A review of Resident 142's admission MDS assessment dated [DATE], indicated in Section K0200 Height and Weight that the resident had a height of 62 inches and weighed 116 pounds.</p> <p>However, review of the resident's weight record revealed that on July 27, 2024 (the date of admission) the resident weighed 115.6 pounds. On July 29, 2024 (the most recent weight prior to the admission MDS assessment), the resident weighed 108.6 pounds.</p> <p>Interview with the facility's registered dietitian (RD) on August 9, 2024, at approximately 12:30 PM, confirmed that Resident 142's admission MDS Assessment section K0200 was coded incorrectly and that Section K0200 should have been coded to reflect the most recent weight prior to the date of the MDS assessment.</p> <p>28 Pa. Code 211.12(c)(d)(1)(5) Nursing services</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to implement a person-centered care plan to meet each resident's needs for four of 21 sampled residents (Residents 7, 8, 64, and 66).</p> <p>Findings including:</p> <p>Review of Resident 8's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include heart failure (chronic condition in which the heart does not pump blood as well as it should), and the presence of a pacemaker (small battery-powered device that prevents the heart from beating too slowly, surgically placed under the skin near the collar bone).</p> <p>A review of the resident's current comprehensive care plan, conducted during the survey ending August 9, 2024, failed to include the presence of a pacemaker. The care plan did not include how the facility would monitor the pacemaker or evaluate the resident for symptoms related to the pacemaker not properly functioning.</p> <p>Interview with the director of nursing on August 8, 2024, at 1:00 PM confirmed that the facility failed to address the care and management of Resident 8's pacemaker on the resident's person-centered plan of care.</p> <p>A clinical record review revealed Resident 7 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease (gradual loss of kidney function).</p> <p>A care plan indicated Resident 7 is at risk for falls related to generalized weakness, poor balance, unsteady gait, and fall from home was initiated on November 15, 2023. Interventions in place to mitigate Resident 7's risk for falling included ensuring her bed is in the lowest position.</p> <p>During an observation and interview on August 6, 2024, at 11:10 AM, in resident room [ROOM NUMBER], Employee 2, Licensed Practical Nurse (LPN), confirmed Resident 7 was in bed and her bed was not in the lowest position. Following inquiries made during the interview, Employee 2, LPN, lowered Resident 7's bed to the lowest position.</p> <p>A clinical record review revealed that Resident 66 was admitted to the facility on [DATE], with diagnoses that include cerebral infarction (brain damage that results from a lack of blood).</p> <p>A care plan indicated Resident 66 is at risk for falls related to impaired mobility and a history of falls in the facility initiated on July 29, 2024. Interventions in place to mitigate Resident 66's risk of falling included ensuring his call bell is within reach.</p> <p>A facility fall risk evaluation dated July 29, 2024, revealed Resident 66 is at high risk of falling.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on August 6, 2024, at 11:40 AM, in resident room [ROOM NUMBER], Employee 3, Nurse Aide (NA), confirmed Resident 66 was in bed and that his call bell was not within reach. Following inquiries made during the interview, Employee 3, NA, picked Resident 66's call bell from the floor and positioned it within reach of the resident.</p> <p>A clinical record review revealed that Resident 64 was admitted to the facility on [DATE], with diagnoses that included osteoarthritis (a degenerative joint disease that occurs when tissues that cushion the ends of bones within the joints break down).</p> <p>A care plan indicated Resident 64 is at risk for falls related to general weakness and a history of noted falls initiated on December 13, 2023. Interventions in place to mitigate Resident 64's risk of falls include a bed clip alarm (a device that will ring to notify staff the resident is attempting to ambulate from bed) and for Resident 64's bed to be in the lowest position.</p> <p>A facility fall risk evaluation dated June 2, 2024 revealed Resident 64 is a high risk for falling.</p> <p>During an observation and interview on August 6, 2024, at 12:20 PM, in resident room [ROOM NUMBER], Employee 4, LPN, confirmed that Resident 64 was in bed and her bed alarm was not connected. Employee 4, LPN, also confirmed that Resident 64's bed was not in the lowest position. Following inquiries made during the interview, Employee 4, LPN, connected Resident 64's bed alarm and lowered the bed to the lowest position.</p> <p>During an interview on August 9, 2024, at approximately 9:30 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed that it is the facility's responsibility to ensure that person-centered care plans are implemented to mitigate residents' risk of falling.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code 211.12(c)(d)(5) Nursing services.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on clinical record review and resident and staff interview, it was determined that the facility failed to ensure comprehensive care plans were developed and revised with participation of the resident and the resident's representative for three residents out of 21 sampled (Residents 15, 31, and 49).</p> <p>Findings include:</p> <p>A clinical record review revealed Resident 15 was admitted to the facility on [DATE], with diagnoses that included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves) and cerebral infarction (brain damage that results from a lack of blood).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 6, 2024, revealed that Resident 15 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</p> <p>During an interview on August 6, 2024, at 11:00 AM, Resident 15 indicated that she has not participated in any recent care plan meetings. She was not able to recall being invited to participate in the development or revision of her care plan. Resident 15 explained that she would be interested in attending because she would like to discuss her discharge options and goals.</p> <p>A clinical record review revealed Resident 31 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease (gradual loss of kidney function) and chronic respiratory failure (a condition where the respiratory system is unable to remove carbon dioxide from or provide oxygen to the body).</p> <p>A review of a quarterly MDS assessment dated [DATE], revealed that Resident 31 is cognitively intact with a BIMS score of 14 (a score of 13-15 indicates cognition is intact).</p> <p>During an interview on August 6, 2024, at 11:25 AM, Resident 31 indicated that she has not participated in any recent care plan meetings. She was not able to recall being invited to participate in the development or revision of her care plan. Resident 31 indicated that she would participate in care plan meetings and participate in the revision or development of her plan of care if invited by the facility.</p> <p>A clinical record review revealed Resident 49 was admitted to the facility on [DATE], with diagnoses that include atherosclerotic heart disease (a condition that involves the buildup of plaque on artery walls).</p> <p>A review of a quarterly MDS assessment dated [DATE], revealed that Resident 49 is cognitively intact with a BIMS score of 15 (a score of 13-15 indicates cognition is intact).</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on observation, review of clinical records, select facility policy, and resident and staff interviews it was determined that the facility failed to timely identify and assess a resident's weight loss, implement individualized nutritional support measures to maintain or improve nutritional parameters, and to timely consult with the physician and notify the resident of a significant weight loss for one resident (Resident 22) and failed to implement a planned nutrition intervention in response to weight loss for one resident (Resident 142) of seven sampled residents.</p> <p>Findings include:</p> <p>A review of facility policy entitled Weight Management Guideline, last reviewed by the facility on May 1, 2024, is the identification of weight loss (planned, or unplanned) to determine accurate weight with supporting documentation to prevent, monitor, or intervene with undesirable weight. Weight variances include weight change of 5 lbs or weight change of 3 lbs if weight less than 100 lbs. If variance is noted, staff will determine if resident has a change such as a splint, edema, prosthesis, new shoes, bag etc. Significant weight variance is defined as:</p> <p>5 % in one month (30 days)</p> <p>7.5% in three months (90 days)</p> <p>10% in six months (180 days)</p> <p>Review of Resident 22's clinical record revealed admission to the facility on [DATE], with diagnoses to have included gastro-esophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), and cerebral atherosclerosis (a build-up of plaques in the blood vessels of the brain).</p> <p>A review of an April 29, 2024, admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted at specific intervals to plan resident care), revealed that the resident was cognitively intact, with a BIMS score (Brief Interview for Mental Status - a tool to assess cognitive function) of 14. Section K 0200 Height and Weight, 152 pounds.</p> <p>Resident 22's clinical record reflected a primary representative (responsible party) as the resident herself.</p> <p>The resident's care plan initiated on April 30, 2024, identified that Resident 22 is at risk for altered nutritional status related to therapeutic diet, diuretic therapy, and diagnosis of COPD, hypertension, GERD, heart failure, and depression, date initiated April 30, 2024, with a noted goal that the resident will not have a significant weight change (gain or loss) through the next review with a target date of September 20, 2024. Interventions planned were to provide meals, snacks, fluids based on resident food preferences and physician orders, review the importance of maintaining the ordered therapeutic diet. Encourage compliance and discuss risks related to not following diet as ordered; honor residents' preferences when choice is made, and periodically obtain resident's weight, evaluate, and report to registered dietician (RD), physician, and family of significant weight changes, date-initiated April 30, 2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Maple Ridge Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Wyoming Avenue Kingston, PA 18704	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a document entitled admission Nutritional Assessment (Mini) MNA dated April 30, 2024, indicated the resident was at risk for malnutrition with a score of 11.0 (a score of 8-11 indicates at risk of malnutrition).</p> <p>A review of the resident's weight record revealed the resident's height as 66.0 inches and that her ideal body weight (IBW) range is between 149.0 - 180.0, with the following recorded weights:</p> <p>April 24, 2024 (12:07 PM) - 151.8 lbs (Admission)</p> <p>May 9, 2024 (2:22 PM) - 151.0 lbs</p> <p>May 14, 2024 (2:58 PM) - 153.6 lbs</p> <p>May 21, 2024 (11:23 AM) - 158.0 lbs</p> <p>May 23, 2024 (2:08 PM) - 158.1 lbs</p> <p>May 31, 2024 (10:30 AM) - 148.0 lbs weight loss (6.39 %) in 8 days</p> <p>June 1, 2024 (10:41 AM) - 148.0 lbs</p> <p>June 4, 2024 (1:30 PM) - 149.0 lbs</p> <p>Resident 22 lost a total of 10.1 lbs. or 6.39 % of body weight in 8 days (May 23, to May 31, 2024).</p> <p>During an interview with alert, and oriented Resident 22 on August 7, 2024, at approximately 9:50 AM, revealed she is a vegetarian who also eats tuna and seafood. In further questioning, the resident indicated being aware of the unplanned weight loss by the way she feels. She stated that staff had not spoken with her regarding her weight loss, and or vegetarian preferences, selections, and or satisfaction. She further stated that staff is well aware of her vegetarian preference and has even voiced concerns, dissatisfaction, with no response from the facility.</p> <p>At the time of the survey ending August 9, 2024, there were no documented evidence that the facility had identified the significant, unplanned weight loss. Nor that a nutritional assessment was conducted and or documentation from the RD regarding the resident's weight loss noted on May 31, 2024. There was no documented evidence that the resident or physician was notified of the weight loss. The resident's weight dropped below the goal range of 149.0 - 180.0 lbs (148.0 lbs. on May 31, and June 1, 2024), but there was no evidence of reassessment by the RD or revision of the resident's care plan or that the RD evaluated the resident's significant weight for additional interventions necessary to deter further weight loss.</p> <p>There was no evidence at the time of the survey ending August 9, 2024, that the facility had timely acted upon the resident's weight loss and developed and implemented nutritional support measures to maintain acceptable nutritional parameters and deter progressive weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Director of Nursing on August 8, 2024, at approximately 9:20 AM, confirmed that the facility failed to timely identify, address, and implement weight loss interventions, and timely notify the resident, and or consult with the physician to improve Resident 22's nutritional status.</p> <p>Review of the clinical record revealed that Resident 142 was admitted to the facility on [DATE], with diagnoses which include subarachnoid hemorrhage (sudden rupture of an aneurysm in an artery in the brain), diabetes, and dysphagia (difficulty swallowing).</p> <p>A review of the resident's weight record revealed the following recorded weights:</p> <p>July 27, 2024 115.6 pounds</p> <p>July 29, 2024 108.6 pounds</p> <p>August 1, 2024 104.6 pounds</p> <p>August 5, 2024 100.4 pounds (reflective of a 13.1% significant weight loss since July 27, 2024)</p> <p>A mini nutritional assessment dated [DATE], indicated the resident weighed 104.6 pounds, had a moderate decrease in food intake, and was malnourished (imbalance between the nutrients your body needs to function and the nutrients it gets).</p> <p>A physician order dated August 7, 2024, noted an order for a Healthshake (nutritional beverage) 4 ounces with meals for weight loss.</p> <p>Observation during the lunch meal on August 9, 2024, at 12:00 PM revealed that the Healthshake was not provided with the resident's lunch as ordered by the physician. Review of the resident's meal ticket failed to indicate that the resident was to receive a Healthshake.</p> <p>Interview with the registered dietitian (RD) on August 9, 2024, at approximately 12:20 PM confirmed that Resident 142 had a significant weight loss and that a 4 ounce Healthshake with meals was ordered by the physician. The RD confirmed that the order for the 4 ounce Healthshake was not added to the resident's meal ticket.</p> <p>Refer 803</p> <p>28 Pa Code 211.10 (c) Resident care policies.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing services.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235</p> <p>Based on a review of clinical records, facility provided documents, facility's planned cycle menu, and resident and staff interviews it was determined that the facility failed to ensure a pre-planned nutritionally adequate menu for one resident out of 21 residents sampled (Resident 22).</p> <p>Findings include:</p> <p>Review of Resident 22's clinical record revealed admission to the facility on [DATE], with diagnoses to have included gastro-esophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), and cerebral atherosclerosis (a build-up of plaques in the blood vessels of the brain).</p> <p>A review of an April 29, 2024, admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted at specific intervals to plan resident care), revealed that the resident was cognitively intact, with a BIMS score (Brief Interview for Mental Status - a tool to assess cognitive function) of 14.</p> <p>A review of facility document entitled Nutritional Risk Assessment/Full - V4 dated April 30, 2024, indicating resident 22 has distinct food preferences, and is a vegetarian but eats fish and seafood. No recommendations at this time, nutrition plan of care (POC) established.</p> <p>A review of facility document entitled Resident Profile indicating the resident is on a regular diet, no meat products, fish ok. Dislikes/intolerances meat, pears, grilled cheese. (Having no mention of her being a vegetarian, and or what her distinct food preferences are).</p> <p>The resident's plan of care (POC) initiated on April 30, 2024, identified that Resident 22 is at risk for altered nutritional status related to therapeutic diet, diuretic therapy, and diagnosis of COPD, hypertension, GERD, heart failure, and depression, date initiated April 30, 2024, with a noted goal that the resident will not have a significant weight change (gain or loss) through the next review with a target date of September 20, 2024. Interventions planned were to provide meals, snacks, fluids based on resident food preferences and physician orders, review the importance of maintaining the ordered therapeutic diet. Encourage compliance and discuss risks related to not following diet as ordered; honor residents' preferences when choice is made, and periodically obtain resident's weight, evaluate, and report to registered dietician (RD), physician, and family of significant weight changes, date-initiated April 30, 2024. (Having no mention of her being a vegetarian, and or what her distinct food preferences are).</p> <p>A review of facility document entitled Resident Council Meeting Minutes dated June 25, 2024, revealing resident 22 had attended, and had voiced concerns, questions regarding food choices, and would like veggie hot dogs, and veggie bacon as stated during an interview with Employee 1, Activity Director, on August 7, 2024, at approximately 2:00 PM.</p> <p>A review of a document entitled June 25, 2024, Food committee resolutions indicating Resident 22 had voiced concerns, questions regarding food choices, and that the facility explained several Pescatarian (primarily a vegetarian diet that includes fish and other seafood) options were available.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the resident' meal ticket dated June 26, 2024, revealed that Resident 22 was on a regular diet, no meat products, fish ok. Dislikes/intolerances meat, pears, grilled cheese. (Having no mention of her being a vegetarian diet - preference).</p> <p>A review of Resident Council Meeting Minutes dated July 23, 2024, made no indication of any follow up, or resolution (old business) regarding resident 22's concern and request for veggie hot dogs, and veggie bacon as stated in the June 25, 2024 Resident Council Meeting Minutes, as confirmed during an interview with Employee 1, Activity Director, on August 7, 2024, at approximately 2:00 PM.</p> <p>During an interview with alert, and oriented Resident 22 on August 7, 2024, at approximately 9:50 AM, revealed she is a vegetarian who also eats tuna and seafood. She stated that staff had not spoken with her regarding her weight loss, and or vegetarian preferences, selections, and or satisfaction. She further stated that staff is well aware of her vegetarian preference and has even voiced concerns, dissatisfaction, with no response from the facility.</p> <p>A review of the facility diet manual reviewed May 1, 2024, revealed that the diet manual did include a vegetarian diet. However, there was no planned menu at the time surveyed of a planned vegetarian diet, as confirmed during an interview with the RD on August 7, 2024, at approximately 2:40 PM.</p> <p>During an interview with the Nursing Home Administrator (NHA) on August 8, 2024, at approximately 10:40 AM, confirmed that the facility failed to plan, in advance, a nutritionally complete vegetarian diet to meet Resident 22's nutritional needs and preferences. The NHA also confirmed the resident had a significant weight loss in 8 days (May 23, to May 31, 2024).</p> <p>Refer F692</p> <p>28 Pa. Code 211.6 (a) Dietary services.</p> <p>28 Pa. Code 201.18 (e)(2)(3) Management</p>		