

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/21/2024
NAME OF PROVIDER OR SUPPLIER  Oak Hill Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1020 North Union Street Middletown, PA 17057	

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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>34631</p> <p>Based on resident and staff interviews, clinical record review, and document review, it was determined that the facility failed to ensure each resident is included and provided the right to participate in the person-centered care planning process for two of 32 residents reviewed (Residents 25 and 31).</p> <p>Findings Include:</p> <p>Review of the facility's New Admission Introduction &amp; Handbook, provided to each resident and/or his representative at admission read, in part, Care plans are created for each resident on admission, reviewed quarterly . You should expect to be invited to participate in Care Plan Meetings routinely.</p> <p>A review of Resident 25's physician's orders revealed diagnoses that included muscle weakness and chronic kidney disease (a long-term condition that occurs when the kidneys are damaged and can't filter blood properly).</p> <p>An interview with Resident 25, on November 18, 2024, at 11:02 AM, revealed he did not recall being invited to his recent quarterly care plan meeting.</p> <p>A review of Resident 25's clinical record failed to reveal any documentation of the Resident's recent invitation and participation in his care plan meetings.</p> <p>A review of Resident 31's physician's orders revealed diagnoses that included anemia (a condition in which the body doesn't have enough healthy red blood cells or the red blood cells don't function properly) and pain.</p> <p>An interview with Resident 31, on November 18, 2024, at 9:47 AM, revealed she did not recall being invited to her recent quarterly care plan meeting.</p> <p>A review of Resident 31's clinical record failed to reveal any documentation of the Resident's recent invitation to and participation in her care plan meetings.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 395347	If continuation sheet Page 1 of 28

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Director of Social Services (Employee 2) on November 20, 2024, at 9:54 AM, revealed she had no process in place to ensure the invitation of residents to participate in their care plan meetings and confirmed all residents, who can participate, should be invited to attend their care plan meetings.</p> <p>28 Pa. Code 201.24 Responsibility of licensee</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>34631</p> <p>Based on document review, clinical record review, and staff interview, it was determined that the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice of non-coverage (SNF-ABN) form to two of three residents to inform those residents of items and services no longer deemed eligible for coverage under Medicare A (Residents 2 and 108).</p> <p>Findings Include:</p> <p>A review of Resident 2's clinical record revealed the last covered day of Medicare A services dated September 1, 2024.</p> <p>Review of the facility's provided notice, revealed the facility did not offer the Resident the SNF-ABN form as Resident 2 was planning to remain in the skilled nursing facility and receive skilled services.</p> <p>A review of Resident 108's clinical record revealed the last covered day of Medicare A services dated August 9, 2024.</p> <p>Review of the facility's provided notice, revealed the facility did not offer the Resident the SNF-ABN form as Resident 108 planned to remain in the skilled nursing facility and receive skilled services.</p> <p>An interview with the Nursing Home Administrator on November 19, 2024, at 1:52 PM, revealed an acknowledgment of the facility providing the incorrect document, which will be corrected going forward.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>37116</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for four of 32 residents reviewed (Residents 33, 37, 46 and 67).</p> <p>Findings include:</p> <p>Review of Resident 33's clinical record revealed diagnoses that included Parkinson's Disease (long-term movement disorder where the brain cells that control movement start to die and cause changes in how one moves, feels, and acts) and moderate protein-calorie malnutrition (insufficient protein intake or protein deficiency).</p> <p>Review of Resident 33's recorded weights revealed that she weighed 100.8 pounds on February 13, 2024, and 89.4 pounds on August 18, 2024, which represented a significant weight loss of 11.31% in this approximately six month period.</p> <p>Review of Resident 33's August 24, 2024, 5 day MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) revealed that a weight of 89 pounds was recorded on this assessment. Further review revealed that the assessment was not coded to indicate that Resident 33 experienced a significant weight loss of greater than 10% in the preceding 6 months.</p> <p>Review of Resident 33's recorded weights revealed that she weighed 84.2 pounds on October 2, 2024, and 79.2 pounds on October 24, 2024, which represented a 5.94% weight loss in this period of time.</p> <p>Review of Resident 33's November 8, 2024, quarterly MDS assessment revealed that a weight of 79 pounds was recorded on this assessment. Further review revealed that the assessment was not coded to indicate that Resident 33 experienced a significant weight loss of greater than 5% in the preceding month.</p> <p>During an interview with Employee 8 (Registered Dietician) on November 21, 2024, at 11:25 AM, she confirmed that Resident 33's August 24, 2024, and November 8, 2024, MDS assessments should have been coded for significant weight loss.</p> <p>During an interview with the Nursing Home Administrator (NHA) on November 21, 2024, at 12:07 PM, he acknowledged that the aforementioned MDS assessments were coded incorrectly.</p> <p>Review of Resident 37's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things), and anxiety disorder (a persistent of feeling of worry, nervousness, or unease).</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 37's clinical record revealed a nursing progress note on November 1, 2024, at 1:49 PM, that stated, Resident seen by Vital Health Solution Services on October 17, 2024. GDR (Gradual dose reduction- tapering of psychotropic medication) clinically advisable. Recommend discontinuing Quetiapine 12.5mg PO daily. After visit summary reviewed by Employee 9 (Nurse Practitioner). No GDR. Recently started and has been stable, reassess next month.</p> <p>Review of Resident 37's MDS with assessment reference date (ARD- last day of the assessment period) of November 2, 2024, it was marked no for Physician documented GDR as clinically contraindicated.</p> <p>During an interview with the NHA on November 21, 2024, at 10:08 AM, he revealed that the Registered Nurse Assessment Coordinator coded the MDS assessment inaccurately as the consult was scanned into the electronic health record later in the month of November 2024. The surveyor discussed the aforementioned notation in the electronic medical record from November 1, 2024, that was available for the assessment. No further information was provided.</p> <p>Review of Resident 46's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders) and anxiety disorder (a persistent of feeling of worry, nervousness, or unease).</p> <p>Review of Resident 46's physician orders revealed an order for Seroquel 25 milligrams (mg) at bedtime for dementia.</p> <p>Review of Resident 46's monthly medication regimen reviews revealed a consultant pharmacist recommendation to Resident 46's physician dated July 26, 2024, that recommended a GDR of Seroquel. Resident 46's physician agreed and signed the form August 5, 2024, with an order to decrease Seroquel to 12.5 mg at bedtime.</p> <p>Review of Resident 46's quarterly minimum data set (MDS - assessment tool utilized to identify a residents' physical, mental, and psychosocial needs) dated October 8, 2024, failed to reveal a GDR had been attempted.</p> <p>During an interview with the NHA on November 20, 2024, at 11:10 AM, it was revealed that the MDS assessment was incorrect and would be corrected. The NHA stated it was the facility's expectation that MDS assessments be coded correctly.</p> <p>Review of Resident 67's clinical record revealed diagnoses that included dementia, hypertension (elevated/high blood pressure), and dysphagia (difficulty swallowing).</p> <p>Review of Resident 67's clinical record revealed a nutrition note from August 6, 2024, that detailed Resident 67 qualified for severe protein calorie malnutrition (PCM) based on weight loss and muscle/fat loss.</p> <p>Review of Resident 67's MDS with ARD of September 23, 2024, it was marked no for Malnutrition (protein, calorie), risk of malnutrition.</p> <p>Review of Resident 67's care plan revealed a focus area Resident 67 is at risk for malnutrition and dehydration, last revised on November 8, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Employee 1 (Regional Director of Clinical Services) on November 20, 2024, at 11:08 AM, revealed at the point of the MDS assessment with ARD of September 23, 2024, Resident 67 was assessed to be at risk of PCM. The surveyor revealed the concern that the question should also be marked yes if a resident were at risk of malnutrition.</p> <p>Follow-up interview with the NHA on November 21, 2024, at 10:06 AM, he revealed the aforementioned MDS assessment should have been marked yes to indicate Resident 67 was at risk of malnutrition.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa Code 211.12(d)(3)(5) Nursing services</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>33305</p> <p>Based on observation, state regulation, resident and staff interviews, record review, policy review, and the facility's licensed staff scope of practice, it was determined that the facility failed to follow professional standards of practice when providing medication administration for 2 of 32 residents reviewed (Residents 31 and 84).</p> <p>Findings include:</p> <p>Review of the Pennsylvania Nursing Practice Act for Licensed Practical Nurses (LPN), Chapter 21.145, revealed Functions of the LPN. (a) The LPN is prepared to function as a member of the health-care team by exercising sound nursing judgement based on preparation, knowledge, experience in nursing and competency. The LPN participates in the planning, implementation and evaluation of nursing care using focused assessment in settings where nursing takes place. (1) An LPN shall communicate with a licensed professional nurse and patient's healthcare team members to seek guidance when the patient's care needs exceed the licensed practical nursing scope of practice.</p> <p>A review of the facility's policy, titled Administering Medications, revised December 2012, read, Medications shall be administered in a safe and timely manner, and as prescribed.</p> <p>A review of Resident 31's clinical record revealed diagnoses that included dry eye syndrome (a common eye condition that occurs when the eyes don't produce enough tears, or the tears aren't working properly. This can lead to discomfort, burning, stinging, or a feeling of a foreign object in the eye. If left untreated, dry eye can cause lasting damage to the cornea and vision problems) and pain.</p> <p>A review of Resident 31's most recent eye consultation dated October 7, 2024, revealed the Resident reported continued dry eye in both eyes.</p> <p>A review of the plan section of the consult form read New Medication Order Systane oph [ophthalmic] solution, apply 2 drops, Both eyes, four times daily for indefinitely.</p> <p>An interview with Resident 31 on November 18, 2024, at 9:47 AM, revealed a concern she was not receiving her ordered eye drops from the eye consult, dated October 7, 2024.</p> <p>A review of Resident 31's current medication orders revealed no physician-ordered eye drops for nursing staff the administer.</p> <p>An interview with the Director of Nursing (DON) on November 20, 2024, at 12:10 PM, confirmed the eye drops were not added to Resident 31's physician orders and were added on November 19, 2024.</p> <p>Review of Resident 84's clinical record revealed diagnoses that included paraplegia (paralysis that affects all or parts of the trunk, legs, and pelvic organs) and sacral (base of spine) pressure ulcer stage 4, recurring (ulcer involving loss of skin layers, exposing muscle and bone).</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physician order dated November 20, 2024, at 9:49 AM, NPWT (negative pressure wound therapy- a common treatment that helps wounds heal by reducing air pressure over the wound) stated cleanse area with normal saline solution or wound cleanser and pat dry, skin prep to peri wound, cut sponge to fit into wound bed and all undermining areas, then complete wound vac application, ensure that wound vac is suctioning at 125 mm/hg (millimeters/mercury).</p> <p>Observation of wound care on Resident 84 on November 20, 2024, at 10:20 AM, revealed the following:</p> <p>Collagen with silver (a wound care product that contains collagen, silver chloride, and other ingredients that help wounds heal) was placed in the wound bed prior to wound vac sponge placement and there was no order for the collagen with silver.</p> <p>Wound care was observed by Employee 11 (Licensed Practical Nurse, Wound Nurse). Employee 11 was observed utilizing the collagen with silver for an area that was bleeding below the wound that required the NPWT. Employee 11 stated, as a certified wound nurse she can apply Collagen Ag as needed.</p> <p>The surveyor verified that Employee 11 had a certificate earned for wound care training. Wound Care Certification requires a Registered Nurse status and additional criteria to be met.</p> <p>A review of the wound care specialty team's last visit and assessment was on November 15, 2024. The wound specialist wrote a new order in their notes to start the NPWT on Monday, November 18, 2024. The facility was questioned as to why the NPWT wasn't started until November 20, 2024. No one could provide an answer.</p> <p>During an interview with the Nursing Home Administrator (NHA) on November 20, 2024, at 1:45 PM, the NHA confirmed there should be physician orders for the Collagen with silver.</p> <p>28 Pa. Code 211.12(d)(1)(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 - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>33305</p> <p>Based on facility policy review, observations, clinical record review, and staff interviews, it was determined that the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing for two of three residents reviewed for pressure ulcers (Resident 64 and 84).</p> <p>Findings include:</p> <p>Review of facility policy, titled Wound Care, last reviewed September 25, 2024, read, in part, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing, Verify that there is a physician's order for this procedure. The policy also states to wash and dry your hands thoroughly prior to the start of the procedure, after removing the soiled dressing, and at the end of the procedure. [NAME] tape with initials, time, date and apply to dressing.</p> <p>Review of Resident 64's clinical record revealed diagnoses that included unspecified severe protein calorie malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets) and pressure ulcer stage 4, reoccurring (wound that occurs when the skin and tissue are damaged by prolonged pressure).</p> <p>Review of Resident 64's clinical record revealed the following physician orders:</p> <p>Wound Care: Sacrum 1) Cleanse w/ wound cleanser or normal saline 2) Pat dry &amp; skin prep peri wound 3) place collagen sheet inside wound 4) Apply TRIAD paste then cover w/ optifoam daily every day shift for Wound Care and as needed for Wound Care if soiled or dislodged, with a start date of September 27, 2024, and discontinued on October 18, 2024.</p> <p>Wound Care: Sacrum 1) Cleanse w/ wound cleanser or normal saline 2) Pat dry &amp; skin prep peri wound 3) place moisten collagen sheet over wound bed &amp; cover w/ optifoam daily every day shift for wound care and as needed for wound care if soiled or dislodged, with a start date of October 18, 2024.</p> <p>Review of Resident 64's wound care consult from October 11, 2024, revealed under new order yes with cleanser of normal saline, primary treatment of collagen +Ag (silver), and secondary treatment of bordered foam dressing.</p> <p>Review of Resident 64's wound care consult from October 18, 2024, revealed the same aforementioned recommendation for a new order.</p> <p>During an interview with the Director of Nursing (DON) on November 21, 2024, at 12:19 PM, she revealed the new order recommendation from October 11, 2024, should have been updated no later than the morning of October 12, 2024, and that when the order was transcribed, the nurse forgot to add the +Ag to the order. No further information was provided.</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 - Some</p>	<p>Review of Resident 84's clinical record revealed diagnoses that included paraplegia (paralysis that affects all or parts of the trunk, legs, and pelvic organs) and sacral (base of spine) pressure ulcer stage 4, recurring (ulcer involving loss of skin layers, exposing muscle and bone).</p> <p>A review of the Resident 84's physician orders on November 20, 2024, at 9:30 AM, revealed orders to cleanse wound with normal saline solution then lightly pack wound with 1/2 strength Dakin's solution soaked gauze BID, cover with ABD pad every day and evening shift.</p> <p>On November 20, 2024, at 10:00 AM, the surveyor followed wound nurse to Resident 84's room, the wound nurse informed the surveyor that orders were changed and a wound vac would be applied today.</p> <p>Physician order dated November 20, 2024, at 9:49 AM, NPWT (negative pressure wound therapy- a common treatment that helps wounds heal by reducing air pressure over the wound) stated cleanse area with normal saline solution or wound cleanser and pat dry, skin prep to periwound, cut sponge to fit into wound bed and all undermining areas, then complete wound vac application, ensure that wound vac is suctioning at 125 mm/hg (millimeters/mercury).</p> <p>Observation of wound care on Resident 84 on November 20, 2024, at 10:20 AM, revealed the following:</p> <p>No hand hygiene was performed before, during, or after the procedure.</p> <p>Resident was on enhanced barrier precautions and no gown was worn during the procedure.</p> <p>The soiled dressing that was removed was not dated.</p> <p>Collagen with silver (a wound care product that contains collagen, silver chloride, and other ingredients that help wounds heal) was placed in the wound bed prior to wound vac sponge placement and there was no order for the collagen with silver.</p> <p>During an interview with the Nursing Home Administrator (NHA) on November 20, 2024, at 1:45 PM, the NHA confirmed that hand hygiene should have been performed, a gown should have been utilized during the procedure, and the soiled dressing that was removed should have been initialed, timed, and dated.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37116</p> <p>Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that residents with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for two of five residents reviewed for mobility (Residents 37 and 55).</p> <p>Findings Include:</p> <p>Review of facility policy, titled Restorative Nursing Services, last reviewed September 25, 2024, read, in part, Residents will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational or speech therapies). Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care.</p> <p>Review of Resident 37's clinical record revealed diagnoses that included contracture of left hand (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen) and dependence on wheelchair.</p> <p>Review of Resident 37's physician orders revealed an order for Splint- patient to have palm guard/carrot in left hand donned during first shift, one time a day for contractures, with a start date of March 8, 2024.</p> <p>Review of Resident 37's nurse aid tasks revealed the following:</p> <p>Maintenance Nursing: Active ROM (range of motion) Left hand staff to assist, last revised April 12, 2022.</p> <p>Maintenance Nursing: Assistance with Splint/Brace Left hand. Wear 4-6 hours a day, last revised April 12, 2022.</p> <p>Review of Resident 37's June 2024 nurse aid task documentation revealed her Active ROM maintenance nursing program was marked not applicable or left blank 25 of 30 days.</p> <p>Further review of Resident 37's June 2024 nurse aid task documentation revealed her splint assistance maintenance nursing program was marked not applicable or left blank 26 of 30 days.</p> <p>Review of Resident 37's July 2024 nurse aid task documentation revealed her Active ROM maintenance nursing program was marked not applicable or left blank 25 of 31 days.</p> <p>Further review of Resident 37's July 2024 nurse aid task documentation revealed her splint assistance maintenance nursing program was marked not applicable or left blank 29 of 31 days.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 37's August 2024 nurse aid task documentation revealed her Active ROM maintenance nursing program was marked not applicable or left blank 29 of 31 days.</p> <p>Further review of Resident 37's August 2024 nurse aid task documentation revealed her splint assistance maintenance nursing program was marked not applicable or left blank 30 of 31 days.</p> <p>Review of Resident 37's September 2024 nurse aid task documentation revealed her Active ROM maintenance nursing program was marked not applicable or left blank 30 of 30 days.</p> <p>Further review of Resident 37's September 2024 nurse aid task documentation revealed her splint assistance maintenance nursing program was marked not applicable or left blank 30 of 30 days.</p> <p>Review of Resident 37's October 2024 nurse aid task documentation revealed her Active ROM maintenance nursing program was marked not applicable or left blank 25 of 31 days.</p> <p>Further review of Resident 37's October 2024 nurse aid task documentation revealed her splint assistance maintenance nursing program was marked not applicable or left blank 25 of 31 days.</p> <p>Review of Resident 37's November 2024 nurse aid task documentation revealed her Active ROM maintenance nursing program was marked not applicable or left blank November 1-14 and 16, 2024.</p> <p>Further review of Resident 37's September 2024 nurse aid task documentation revealed her splint assistance maintenance nursing program was marked not applicable or left blank November 1-14 and 16, 2024.</p> <p>During an interview with the Nursing Home Administrator (NHA) on November 21, 2024, revealed he would expect nurses to be documenting that the Resident refused rather than marking not applicable for the program if the Resident refused, and consistent refusals should be evaluated for lack of tolerance to the program to determine if it continues to be indicated.</p> <p>Review of Resident 55's clinical record revealed diagnoses that included hemiplegia and hemiparesis following cerebral infarction (inability to move, severe weakness, or rigid movement on either the right or left side of the body due to stroke) and lack of coordination.</p> <p>During an interview with Resident 55 on November 19, 2024, at 11:00 AM, she revealed that she is supposed to walk with her walker daily with the assistance of nursing staff, but that she has trouble getting anyone to help her with this.</p> <p>Review of Resident 55's Kardex (care guide for use by nursing staff) revealed Ambulation: The resident is to walk to and from dining room [ROOM NUMBER]x/day with walker and WC [wheelchair] follow. This was last revised September 27, 2024.</p> <p>Further review of Resident 55's clinical record failed to reveal any documented evidence that this ambulation program was occurring daily.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the NHA on November 20, 2024, at 11:33 AM, he revealed that when the task was entered it appeared on Resident 55's Kardex, but it was not entered so that it could be documented on. He revealed the expectation that nursing staff should be documenting when they are assisting Resident 55 with ambulation.</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 - Some</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>48484</p> <p>Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding, including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers, for two of three residents reviewed for tube feeding (Resident 53 and 67).</p> <p>Findings include:</p> <p>Review of facility policy, titled Enteral Nutrition, last reviewed September 25, 2024, read, in part, Adequate nutrition support through enteral nutrition will be provided to residents as ordered.</p> <p>Review of Resident 53's clinical record revealed diagnoses of hemiplegia and hemiparesis following cerebral infraction (weakness or the inability to move one side of the body due to blocked or reduced blood flow to the brain) and dysphagia (difficulty swallowing).</p> <p>Review of Resident 53's physician orders revealed an order for bolus feeding via gastrostomy tube (G-tube - a small flexible tube that is surgically placed into the stomach to deliver nutrition, fluids, and medicine) five times daily.</p> <p>Further of Resident 53's physician orders failed to revealed orders for g-tube site monitoring and care and syringe changes.</p> <p>During an interview on November 21, 2024 at 10:13 AM, with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Employee 1, it was revealed that Resident 53 should have had orders in place for G-tube site monitoring and care and syringe changes. The NHA stated it was the facility's expectation that orders be in place to provide appropriate care.</p> <p>Review of Resident 67's clinical record revealed diagnoses that included gastrostomy with PEG tube (G-tube), dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), and dysphagia.</p> <p>Review of Resident 67's physician orders revealed an order for Peg tube syringe to be changed 1 time weekly on Sundays, every night shift every Sunday, with a start date of March 31, 2024.</p> <p>Further review of Resident 67's physician orders revealed she gets bolus enteral feedings (a set amount of enteral formula without use of a continuous pump) five times a day.</p> <p>During an interview with the DON on November 20, 2024, at 11:18 AM, she revealed Resident 67 gets set feeding throughout the day via an open system where individual cartons are poured into open bags and administered via her PEG tube.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Follow up interview with the DON on November 21, 2024, at 10:06 AM, she revealed that Resident 67 should have orders for the PEG tube syringe to be changed daily and not weekly, and the order had been updated to reflect the same.</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) 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>47966</p> <p>Based on facility policy review, observations, clinical record review, and resident and staff interviews, it was determined the facility failed to provide respiratory care consistent with professional standards of practice for one of two residents reviewed for respiratory care (Resident 22).</p> <p>Findings include:</p> <p>Review of facility policy, titled Oxygen Administration, last reviewed September 2024, read, in part, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.</p> <p>Review of Resident 22's clinical record revealed diagnoses that included bipolar disorder (a serious mental illness that causes extreme mood shifts, including periods of mania and depression) and hypertension (high blood pressure).</p> <p>Observation of Resident 22 on November 18, 2024, at 10:38 AM, revealed the Resident was sitting in their room, using oxygen running at 4 liters per minute.</p> <p>Observation of Resident 22 on November 20, 2024, at 12:23 PM, revealed the Resident was sitting in their room, using oxygen running at 4 liters per minute.</p> <p>During an interview with Resident 22 on November 18, 2024, at 10:40 AM, revealed that the Resident has been using oxygen daily since being admitted in October 2024.</p> <p>Review of Resident 22's care plan revealed a focus area of, Resident 22 has altered respiratory status/difficulty breathing related to chronic obstructive pulmonary disorder, interstitial lung disease, chronic respiratory failure, as well as an intervention of, oxygen settings: oxygen via nasal prongs at 2 liters as ordered, with an initiation date of November 4, 2024.</p> <p>Review of Resident 22's clinical record revealed a physician's order for oxygen at 2 liters, with an active date of October 26, 2024.</p> <p>Further review of Resident 22's current physician's orders revealed a new order to change humidifier bottle once weekly on Tuesday during the Night shift and as needed, with a start date of November 18, 2024; clean oxygen concentrator filter once weekly on Tuesday during the Night shift and as needed, with a start date of November 18, 2024; and change oxygen tubing/extension tubing/canister with tubing/with drain bag, with a start date of November 18, 2024.</p> <p>Review of Resident 22's October 2024 Treatment Administration Record and November 2024 Treatment Administration Record failed to reveal documentation indicating that Resident 22 has had their oxygen humidifier bottle changed prior to November 19, 2024, as well as had their oxygen concentrator filter cleaned or their oxygen tubing changed prior to November 19, 2024.</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>During an interview with the Director of Nursing on November 21, 2024, at 10:14 AM, revealed Resident 22 should have a titrate oxygen order and that their baseline is 2 liters per minute, but if the Resident was doing an activity, it gets bumped up to 4 liters per minute.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47966</b></p> <p>Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that residents who require dialysis receive such services consistent with professional standards, and failed to maintain complete and accurate records related to dialysis communication for one of one resident reviewed for dialysis (Resident 326).</p> <p>Findings include:</p> <p>Review of facility policy, titled Hemodialysis Access Care, last reviewed September 2024, read, in part, Do not use the access site arm to take blood pressure.</p> <p>Review of Resident 326's clinical record revealed diagnoses that included ESRD (End Stage Renal Disease - failure of kidney function to remove toxins from blood), hypertension (elevated/high blood pressure), and diabetes mellitus (a form of diabetes that is characterized by high blood sugar, insulin resistance, and relative lack of insulin).</p> <p>Review of Resident 326's care plan revealed a focus area of Resident needs dialysis with an intervention for do not draw blood or take blood pressure in arm with graft, initiated on November 06, 2024.</p> <p>Review of Resident 326's current active physician orders on November 19, 2024, at 10:48 AM, revealed no active order for dialysis.</p> <p>Review of Resident 326's blood pressure measures revealed blood pressures were documented in his arm with his dialysis access (left arm) on November 8, 9, 12, 13, 16, 18, and 19, 2024.</p> <p>Review of Resident 326's dialysis communication sheets provided revealed a missing communication sheet on November 6, 2024.</p> <p>During an interview with Resident 326 on November 19, 2024, at approximately 9:35 AM, revealed the Resident attends dialysis on Mondays, Wednesdays, and Fridays since the Resident was admitted to the facility on [DATE].</p> <p>Review of Resident 326's current active physician orders on November 20, 2024, at 1:32 PM, revealed an order for dialysis on Monday, Wednesday, Friday; and weigh Resident prior to going to dialysis every day shift every Monday, Wednesday, Friday related to End Stage Renal Disease, with an active date of November 20, 2024.</p> <p>Review of Resident 326's clinical record revealed the facility failed to weigh the Resident prior to going to dialysis on November 6, 8, 11, 13, 15, and 18, 2024.</p> <p>Review of Resident 326's clinical record revealed he was started on dialysis on November 6, 2024, however did not have a dialysis order until November 20, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Nursing Home Administrator on November 20, 2024, at 11:23 AM, confirmed that Resident 326's dialysis order was not in timely, and he would have expected it to have been put in when Resident 326 was admitted to the facility, as well as had a communication form from November 6, 2024.</p> <p>During an interview with the Director of Nursing on November 21, 2024, at 10:13 AM, revealed that the staff recording Resident 326's blood pressure documented incorrectly and would have expected them to document the correct arm blood pressure is taken in.</p> <p>28 Pa code 211.5(f) Medical records</p> <p>28 Pa Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37116</b></p> <p>Based on policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to complete a timely assessment for trauma and then develop and implement an individualized person-centered care plan to render trauma-informed care to a resident with a diagnosis of Post-Traumatic Stress Disorder (PTSD) for two of 32 residents reviewed (Residents 10 and 105).</p> <p>Findings include:</p> <p>Review of facility policy, titled Trauma-Informed Care, last revised September 25, 2024, read, in part, Policy Statement .Care will be provided in a manner that prevent re-traumatization and promotes healing and empowerment. Procedures 2. Resident Assessment and Care Planning: Incorporate trauma screening into resident assessments to identify potential trauma histories. Develop individualized care plans that account for trauma-related needs, preferences, and triggers.</p> <p>Review of Resident 10's clinical record revealed diagnoses that included Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event. The condition may last months or years, with triggers that can bring back memories of the trauma, accompanied by intense emotional and physical reactions) and diffuse traumatic brain injury (occurs when the brain rapidly shifts in the skull causing tissue damage).</p> <p>Further review of Resident 10's clinical record revealed an admitted [DATE].</p> <p>Additional review of Resident 10's clinical record failed to reveal any trauma informed care assessments or follow-up care relating to Resident 10's PTSD diagnosis.</p> <p>Review of Resident 10's comprehensive plan of care revealed a focus area for PTSD. Further review of Resident 10's care plan failed to indicate the source of Resident 10's PTSD or any known triggers.</p> <p>During an interview on November 20, 2024 at 11:04 AM, with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Employee 1, it was revealed that no trauma assessment had been completed and no additional information could be provided. The NHA stated it was the facility's expectation that trauma informed care be provided.</p> <p>Review of Resident 105's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD - chronic inflammatory lung disease that causes obstructed airflow from the lungs) and congestive heart failure (CHF - weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues).</p> <p>Further review of Resident 105's clinical record revealed she was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 105's nursing progress notes dated November 6, 2024, revealed, Resident requests to continue therapy session with her VA [Veterans Affairs] counselor for her PTSD. Notified Social services.</p> <p>Review of Resident 105's nursing progress notes dated November 15, 2024, revealed in part, res [resident] then stated, When I'm this upset it triggers my PTSD and raise her fist also stating, and its not pretty when its triggered.</p> <p>During an interview with Resident 105 on November 21, 2024, at 9:37 AM, she confirmed that she has experienced traumatic events in the past and that some of the things that trigger her include the sounds of gun fire and fighting, and when someone comes up behind her. She also revealed that she wishes to continue VA counseling and has an upcoming appointment.</p> <p>Review of Patient Health Questionnaire completed by social services on September 25, 2024, revealed a hand-written note sensitive to light - PTSD.</p> <p>Review of Resident 105's diagnosis list and care plan failed to indicate any evidence of a PTSD diagnosis, information regarding her triggers, or any personalized interventions to prevent re-traumatization.</p> <p>During an interview with the DON on November 20, 2024, at 10:05 AM, she revealed that she was not able to locate any information regarding a PTSD diagnosis in Resident 105's clinical records, including those that accompanied her upon admission; however, when she contacted the VA, they confirmed that Resident 105 received services in the past for PTSD.</p> <p>During an interview with the NHA on November 21, 2024, at 12:08 PM, he revealed that social services should be doing an initial assessment for past trauma and making sure that information is included in the Resident's plan of care.</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 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>34631</p> <p>Based on observations, facility policy review, clinical record review, and staff interview, it was determined that the facility failed to assess residents utilizing enabler bars/side rails for risk of entrapment, review the risks and benefits of the use of enabler bars/side rails with residents or their representatives, and obtain informed consent for enablers bars/side rails prior to use for two of three residents reviewed for use of enablers (Residents 84 and 105).</p> <p>Findings Include:</p> <p>A review of facility policy, Proper Use of Side Rails, undated, revealed, An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails .The use of side rails as an assistive device will be addressed in the resident care plan .Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks.</p> <p>A review of Resident 84's physician's orders revealed diagnoses that included paraplegia (paraplegia is the loss of muscle function in the lower half of the body, including both legs, and morbid obesity) and morbid obesity (A disorder that involves having too much body fat, which increases the risk of health problems).</p> <p>An observation of Resident 84's bed, on November 18, 2024, at 11:09 AM, revealed bilateral side rails attached to his bed.</p> <p>A review of Resident 84's clinical record revealed no documentation of a signed consent or a review of the risks and benefits of the use of the side rails with the Resident and/or his Representative.</p> <p>A review of Bed Rail Safety and Informed Consent Form revealed that it was not signed by Resident 84 until November 19, 2024.</p> <p>A review of Resident 105's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD - chronic inflammatory lung disease that causes obstructed airflow from the lungs) and congestive heart failure (CHF - weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues).</p> <p>Observation of Resident 105's bed on November 18, 2024, at 10:42 AM, revealed an enabler rail on the left side of the bed.</p> <p>A review of Resident 105's Side Rail/Entrapment Risk Evaluation portion of the Nursing Admission/Readmission Evaluation Packet, completed on September 26, 2024, revealed that side rails were not necessary at that time.</p> <p>A review of Resident 105's physician orders revealed an order for side rail to left side, effective September 26, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident 105's clinical record revealed no additional evidence that she was evaluated as appropriate and/or safe for the use of enabler/rails on her bed.</p> <p>A review of Bed Rail Safety and Informed Consent Form revealed that it was not signed by Resident 105 until November 19, 2024.</p> <p>During an interview with the Nursing Home Administrator on November 20, 2024, at 1:37 PM, he confirmed that they were unable to locate any additional assessment that had been completed to evaluate Resident 105 for use of an enabler/rail. He also revealed the expectation that consent for use of the enabler/rail should have been timely for both Residents 84 and 105, and that an assessment should have been completed to determine that the enabler/rail was appropriate for use on Resident 105's bed.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</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>47966</p> <p>Based on observation, policy review, and resident and staff interviews, it was determined that the facility failed to ensure that prescription medications and treatments were stored in locked compartments and only accessible by authorized personnel for three of 32 residents reviewed (Residents 2, 80, and 84).</p> <p>Findings Include:</p> <p>A review of facility policy, Self-Administration of Medications, revised December 2016, revealed, Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration.</p> <p>A review of Resident 2's clinical record revealed diagnoses that included pain and rash.</p> <p>An observation in Resident 2's room on November 18, 2024, at 10:42 AM, revealed a medication cup with a powder substance at the Resident's bedside.</p> <p>When an inquiry was made, Resident 2 stated staff leave the powder there in order to have it available for use for the rash under her breasts.</p> <p>An interview with the Assistant Director of Nursing (Employee 3), at 10:45 AM, revealed the powder is used during resident care and should not be stored at the Resident's bedside. The powder was immediately removed from Resident 2's room.</p> <p>An additional interview with the Director of Nursing (DON) on November 20, 2024, at 11:45 AM, revealed the powder should not have been left at the Resident's bedside for staff convenience and Resident 2 has no orders for self-administration of medications and/or treatments.</p> <p>Review of Resident 80's clinical record revealed diagnoses that included congestive heart failure (CHF - weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues), rash, and other nonspecific skin eruption.</p> <p>Observation on November 18, 2024, at 10:17 AM, revealed a tube of Nystatin-Triamcinolone cream (antifungal cream) and a bottle of Nystatin powder (antifungal) in a wash basin on Resident 80's bed.</p> <p>During an immediate interview with Resident 80, she revealed that she did not apply these medications herself but that the nurse applies them and leaves them in her room for convenience.</p> <p>Review of Resident 80's orders revealed that the order for Nystatin-Triamcinolone cream was discontinued on November 6, 2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/21/2024
NAME OF PROVIDER OR SUPPLIER  Oak Hill Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1020 North Union Street Middletown, PA 17057	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the DON on November 20, 2024, at 1:41 PM, she confirmed that Resident 80 does not self-administer her medications, and that she would expect the Nystatin cream and powder to have been stored in the treatment or medication cart.</p> <p>Review of Resident 84's clinical record revealed diagnoses that included paraplegia (paralysis that affects all or parts of the trunk, legs, and pelvic organs) and sacral (base of spine) pressure ulcer stage 4, recurring (ulcer involving loss of skin layers, exposing muscle and bone).</p> <p>An observation in the Resident's room on November 18, 2024, at 11:12 AM, revealed a medication cup with a cream at the Resident's bedside. It was later determined the cream to be Triad (a sterile coating that can be used on broken skin).</p> <p>An interview with Resident 84 revealed staff leaves the cream there at his bed in anticipation of providing care to his wounds.</p> <p>An interview with the DON revealed the cream should not have been left at the Resident's bedside for staff use or convenience. Also, the Resident has no self-administration of medication and/or treatment orders.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services</p>		

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NAME OF PROVIDER OR SUPPLIER  Oak Hill Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1020 North Union Street Middletown, PA 17057	

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>37116</p> <p>Based on clinical record review and resident and staff interviews, it was determined that the facility failed to provide or obtain dental services to meet the needs of each resident for one of one residents reviewed for dental concerns (Resident 80).</p> <p>Findings include:</p> <p>Review of Resident 80's clinical record revealed diagnoses that included congestive heart failure (CHF - weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues) and vitamin deficiency.</p> <p>During an interview with Resident 80 on November 18, 2024, at 10:17 AM, she revealed that she was concerned that the facility did not do routine dental care. She also revealed that she has her own teeth and is used to taking good care of them.</p> <p>Review of dental consult form dated December 1, 2023, revealed that recommended treatment included dental prophy (prophylaxis - dental cleaning and checkup) in six months.</p> <p>Further review of Resident 80's clinical record failed to reveal evidence that any additional dental services were received since her visit on December 1, 2023.</p> <p>During an interview with the Nursing Home Administrator on November 20, 2024, at 1:43 PM, he revealed that the dental provider is supposed to track and schedule follow-up appointments, but that the facility needs to put a system in place to track these appointments as well.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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NAME OF PROVIDER OR SUPPLIER  Oak Hill Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1020 North Union Street Middletown, PA 17057	

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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>33305</p> <p>Based on observation, policy review, and staff interviews, it was determined that the facility failed to ensure enhanced barrier precautions were implemented appropriately to maintain a safe and sanitary environment that supports infection prevention and control for one of 20 residents on enhanced barrier precautions (Resident 102) and residents not on enhanced barrier precautions (Residents 41 and 66).</p> <p>Findings include:</p> <p>Review of the facility policy, titled Enhanced Barrier Precautions (EBP), effective April 1, 2024, stated, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are indicated for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care.</p> <p>Observation during tour of the nursing units on November 18, 2024, at 10:00 AM, revealed EBP signage on Resident 41, Resident 66, and Resident 102's door. There was no personal protection equipment (PPE) storage bin located outside of the room or on a door hanger. Employee 14 (Nurse Aide) was observed at Resident 102's bedside bagging soiled linen and not wearing a gown.</p> <p>Employee 14 and Employee 13 (Licensed Practical Nurse) were asked the reason for the EBP on all three Residents, and could only provide a reason for Resident 102 who had open wounds.</p> <p>During an interview with Employee 12 (Infection Control Professional ICP) on November 18, 2024, at 10:17 AM, she confirmed that a PPE bin should have been present for staff, and gowns and gloves should be utilized during any direct care provided to the Resident. The ICP removed signage from both Resident 41 and Resident 66's door because EBP did not apply to those Residents.</p> <p>During an interview with the Nursing Home Administrator and Director of Nursing on November 20, 2024, at 1:45 PM, both agreed that only residents on EBP should have signage on their doors, all staff should be aware of the reason for EBP, and appropriate PPE should always be utilized with EBP.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>34631</p> <p>Based on observations, policy review, clinical record review, and staff interviews, it was determined that the facility failed to conduct regular inspections of side rails/enabler bars to identify areas of possible entrapment for two of three residents reviewed for side rails/enabler bars (Residents 43 and 105).</p> <p>Findings include:</p> <p>A review of facility policy, Proper Use of Side Rails, undated, revealed, When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used).</p> <p>A review of Resident 43's clinical record revealed diagnoses that included abnormalities of gait (the manner of a person's walking) and mobility (the ability to move freely) and hypertension (elevated blood pressure).</p> <p>An observation of Resident 43's bed, on November 18, 2024, at 10:59 AM, revealed bilateral enabler bars attached to the Resident's bed.</p> <p>An interview with the Nursing Home Administrator (NHA) on November 21, 2024, at 9:51 AM, revealed the bilateral rails were installed on November 15, 2024, and measurements for the safety of the rails were not documented until November 20, 2024.</p> <p>A review of Resident 105's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD - chronic inflammatory lung disease that causes obstructed airflow from the lungs) and congestive heart failure (CHF - weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues).</p> <p>Observation on November 18, 2024, at 10:42 AM, revealed a side rail/enabler installed on the left side of Resident 105's bed.</p> <p>A review of Resident 105's orders revealed an order for a side rail to the left side of the bed, effective September 26, 2024.</p> <p>A review of Resident 105's clinical record and other available facility documentation failed to reveal any inspection or measurement of the side rail/enabler to identify possible areas of entrapment.</p> <p>During an interview with the NHA on November 21, 2024, at 12:06 PM, he confirmed that he was unable to locate any evidence that Resident 105's enablers/ side rails had been measured or inspected to identify possible entrapment concerns.</p> <p>28 PA Code 201.18(b)(1) Management</p>		