STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395350	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Locust Grove Retirement Village	69 Cottage Road Mifflin, PA 17058

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 38839 Based on observation, clinical record review, review of facility documents, and resident and staff interview, it was determined that the facility failed to protect the rights of a resident to be free from neglect by not providing the services necessary to avoid physical harm related to a sustained fracture on one of two nursing units, (Unit 100-300, Resident 33). This deficiency is cited as past noncompliance Findings include: Observation and interview with Resident 33 on May 1, 2024, at 9:49 AM revealed the resident was in bed. Resident 33 stated one person gave her a couple fractures and stated, She tried to get me into bed, she didn't use the lift. Resident 33 stated she hurt after that, and it was her fault, referencing the staff member. Resident 33 said her knee was broken. Clinical review for Resident 33 revealed an active physician's order dated November 8, 2023, for the resident to use a full mechanical lift as her transfer status. Review of Resident 33's plan of care revealed the resident requires a mechanical lift with two staff assistance for transfers initiated on the plan of care on October 13, 2022. A nursing note dated March 24, 2024, at 2:24 PM noted the resident began complaining of left knee pain that hurt after being bumped during transfer the day before. The note indicated there was no concern or swelling noted of the knee. An x-ray of Resident 33's left knee completed on March 25, 2024, revealed the resident had an acute fracture of the left lateral tibial plateau. The facility initiated an investigation on March 26, 2024, into Resident 33's acute knee fracture and upon resident interview dated March 26, 2024, the resident stated a staff member got her out of bed by herself and twisted her knee while lifting her. Review of staff statements obtained by the facility revealed the resident had mentioned several different staff members as individuals who transferred her independently. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on a staff statement from Employee 15 (resident assistant) dated March 26, 2024, revealed that Employee 16 (nurse aide) was witnessed getting Resident 33 out of bed by just picking her up and putting her in the wheelchair to got to the dining area on March 23, 2024. Review of a telephone interview documented by facility staff dated March 26, 2024, with Employee 16 indicated the nurse aide indicated she did get Resident 33 out of bed, but indicated she used the Hoyer lift by herself to get the resident out of bed and indicated she knew two people were to be used with the lift. Employee 16 stated the resident did not express pain during the transfer but did hear a pop when she rolled her in bed when lunch was over. A review information submitted by the facility on March 28, 2024, indicated the facility had completed an investigation into Resident 33's reported knee pain and allegation of only being transferred with one person, and sustaining a fracture. The facility interviewed all staff working in the time frame surrounding the incident and determined Employee 16 did not follow Resident 33's plan of care regarding the mechanical lift for transfers with two people, and Employee 16 admitted there was not a second person present. Employee 16 was terminated from the facility on March 26, 2024. The facility provided staff education on using the correct transfer status when providing residents with care and transfers on March 26, 2024. Review of a facility implemented plan of correction, signed by facility administration during an Ad Hoc quality assurance (QA) meeting on March 26, 2024, revealed that the facility implemented the following: Random audits of transfers will be completed by the director of clinical services or their designee. The results will be reported at the April 18, 2024, QAPI meeting. Review of the audits dated March 26 and 27, 2024, revealed that staff were appropriately transferring residents utilizing the required staff. Review of the QAPI meeting dated April 25, 2024, revealed that the transfer audits were reviewed with no trends noted. Random audits on each shift will continue for another month. These results will be reviewed at the May QAPI meeting for further recommendation. The Ad Hoc meeting also indicated that staff continue to be educated on proper transfer status at orientation and as needed. The above findings were confirmed with the Nursing Home Administrator and Director of Nursing on May 3, 2024, at 11:30 AM. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839 Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide bathing assistance for a resident dependent on staff assistance for five of seven residents reviewed for activities of daily living (Residents 33, 39, 47, 52, and 63). Findings include: Interview with Resident 33 on May 1, 2024, at 9:52 AM revealed she is to get showered on Tuesdays and Fridays, during the day, and she doesn't refuse them, but stated she had a fracture and maybe that's why she wasn't getting them. Clinical record review for Resident 33 did reveal the resident had sustained a fracture in her leg in March 2024, and was scheduled to receive showers on Tuesdays and Fridays on the 2-10:00 PM shift and as needed. A review of Resident 33's bathing records for April 2024, revealed the resident was totally dependent on staff for bathing, and did receive a shower on April 2 and April 9, 2024, on her scheduled shower days after her fracture, but had only received a bed bath on April 5, 23, and 26; a partial bed bath on April 19 and 30; and April 16 was noted as response not required. There was no evidence Resident 33 could not receive a shower due to her fracture nor any documented showers on an as needed basis outside of her scheduled shower days. In a follow up interview with Resident 33 on May 3, 2024, at 10:45 AM regarding only receiving a partial bed bath on April 30, 2024, the resident stated she could not get a shower because there was only one. When the resident was asked one what? the resident stated, one girl, referencing the staff. Resident 33 again stated she would not refuse to be showered per her preference. There was no evidence Resident 33 received a shower since April 9, 2024. The above concerns regarding Resident 33's bathing being completed per the resident's bathing preference were reviewed with the Nursing Home Administrator and Director of Nursing on May 3, 2024, at 11:38 AM. Review of Resident 47's clinical record revealed a Minimum Data Set Assessment (MDS, an assessment tool completed at specific intervals to determine care needs) dated October 12, 2023, that the facility assessed her as being dependent on staff assistance for bathing. An MDS dated [DATE], determined that it was very important for Resident 47 to be able to decide on whether she gets a bed bath or shower. Review of Resident 47's bathing documentation dated April 2024, revealed that she has not received a shower since April 9, 2024. There was no documented evidence in Resident 47's clinical record to indicate that the facility determined her preferences for bathing. Review of Resident 52's clinical record revealed an MDS dated [DATE], that indicated the facility determined she was dependent on staff assistance for bathing. An MDS dated [DATE], determined that it was very important for Resident 52 to be able to decide on whether she gets a bed bath or shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident 52 on April 30, 2024, at 12:00 PM revealed that she is not getting her showers like she is supposed to. Resident 52 indicated that she is supposed to get a shower two times a week. Review of Resident 52's bathing documentation dated April 2024, revealed that she has not received a shower since April 18, 2024. Review of Resident 63's clinical record revealed an MDS assessment dated [DATE], that indicated the facility assessed him as being dependent on staff assistance for bathing. Review of Resident 63's bathing documentation dated April 2024, revealed that he has not received a shower since April 9, 2024. Resident 63 has only received partial bathing since April 16, 2024. There was no documented evidence in Resident 63's clinical record to indicate his preferences regarding receiving a bed bath or a shower. Interview with the Administrator and Director of Nursing on May 2, 2024, at 1:45 PM acknowledged the above findings for Residents 47, 52, and 63, and confirmed that the facility has not obtained any resident preferences for bathing. Review of Resident 39's clinical record revealed his most recent quarterly MDS dated [DATE], revealed that the facility assessed him as being dependent on staff assistance for bathing. Resident 39 was unable to be interviewed due to his current cognitive status. A review of Resident 39's task documentation (ADL, activities of daily living charting) revealed he preferred to receive a shower/bath/bed bath two times a week on the second shift. A review of Resident 39's task documentation revealed that he only received one shower in the last month, he received eight partial, or bed baths. There was no documented evidence in Resident 39's clinical record to indicate his preferences regarding the type of shower, tub bath, or bed bath he preferred to receive. Interview with the Administrator and Director of Nursing on May 2, 2024, at 1:45 PM acknowledged the above findings for Resident 39 and confirmed that the facility has not obtained any resident preferences for bathing. Refer to F725. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 38839 Based on clinical record review, review of facility documents, and resident, family member, and staff interview, it was determined that the facility failed to have sufficient nursing staff to meet resident's needs for four of 24 residents reviewed (Resident 28, 33, 52, and 64). Findings include: A review of a facility complaint/grievance form dated March 6, 2024, noted a resident concern regarding call bell response times. The investigation to the concern was noted as completed on March 25, 2024, by a registered nurse, and indicated, Call bell response times have increased due to staffing shortages, response times are monitored and while it is found to have increased response time, it is not because staff are choosing to not respond it is simply because that are extremely busy. The concern form had not yet been noted as resolved as of May 3, 2024. Facility nurse staffing was reviewed for the week of March 22 - March 28, 2024, which included the March 25, 2024, date the grievance investigation was completed and reflected the facility had an average staffing of 2.66 hours per patient day, below the state minimum of 2.87. The facility only met the minimum one day during the week and fell below on the dates indicated below: March 22, 2024, 2.48 March 23, 2024, 2.64 March 24, 2024, 2.74 March 25, 2024, 2.53 March 26, 2024, 2.78 March 28, 2024, 2.38 In an interview with Resident 13, on April 30, 2024, at 11:40 AM the resident indicated she will often wait when she rings her call bell for care to be completed but was patient and understood because the facility was short staffed, and the staff are really busy. Resident 13 did not wish to provide specifics on call bell wait times. In an interview with Resident 33 on May 1, 2024, at 9:52 AM the resident stated she is to get showered on Tuesdays and Fridays, during the day, and doesn't refuse them, but stated she had a fracture and, that's maybe why she wasn't getting them. Clinical record review for Resident 33 did reveal the resident had sustained a fracture in her leg in March 2024, and was scheduled to receive showers on Tuesdays and Fridays on the 2-10:00 PM shift and as needed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 33's bathing records for April 2024, revealed the resident was totally dependent on staff for bathing, and did receive a shower on April 2 and April 9, 2024, on her scheduled shower days after her fracture, but had only received a bed bath on April 5, 23, and 26; a partial bed bath on April 19 and 30; and April 16 was noted as response not required. There was no evidence Resident 33 could not receive a shower due to her fracture nor any documented showers on an as needed basis outside of her scheduled shower days. In a follow up interview with Resident 33 on May 3, 2024, at 10:45 AM regarding only receiving a partial bed bath on April 30, 2024, the resident stated she could not get a shower because there was only one. When the resident was asked one what? the resident stated, one girl, referencing the staff. Interview with Resident 28 on April 30, 2024, at 11:34 AM revealed that the facility is short-staffed. He stated it could take a long time for staff to respond to his call bell due to not having enough staff. Resident 28 stated that he has waited for 30 to 45 minutes for the staff to take him to the bathroom. A review of facility staffing for the resident's scheduled shower day of April 30, 2024, revealed the facility did not meet state minimum requirement for nurse staffing for the day as follows: Dayshift: 5.0 nurse aides, required 6.58. 2.0 licensed practical nurses, required 3.16. Evening shift: 1.5 nurse aides, required 6.58. The facility's nursing hours per patient day for April 30, 2024, was 2.13 below the state minimum of 2.87. Interview with Resident 52 on April 30, 2024, at 12:06 PM revealed that she is not getting her showers. Resident 52 indicated it might be because the facility never has enough staff. Interview with Resident 64's responsible part on April 30, 2024, at 12:45 PM revealed that his mother has to wait a long time for call bells because they don't have enough staff. Interview with the Director of Nursing on May 2, 2024, at 10:50 AM revealed that the facility accepted a new admission on May 1, 2024, despite not being able to meet the minimum number of staff required for the current census. The above concerns regarding grievance response and resident care completion with staffing was reviewed with the Nursing Home Administrator and Director of Nursing on May 3, 2024, at 11:38 AM. Refer to 677 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.18(e)(1)(6) Management 28 Pa. Code 211.12(d)(1)(3)(4)(5) (f)(f.1)(2)(3)(4) (i)(1) Nursing services

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 20725 Based on review of select facility policies and procedures, observation, and review of personnel records, it was determined that the facility failed to ensure specific competencies necessary to care for resident needs for one of two residents reviewed for intravenous access concerns (400 hall nursing unit, Resident 74, Employee 7). Findings include: The facility policy entitled, Peripheral Intravenous Catheter Flushing, last reviewed without changes on March 29, 2024, revealed that infusion therapy in the post-acute care facility is performed by licensed nurses according to state law and facility policy. The nurse is responsible and accountable for obtaining and maintaining competence with infusion therapy within his or her scope of practice. Competency validation is documented in accordance with organizational policy. According to, Pennsylvania Code, Title 49, Chapter 21, Functions of the LPN, an LPN (licensed practical nurse) may perform only the IV (intravenous) therapy functions for which the LPN possesses the knowledge, skill, and ability to perform in a safe manner. Observation of the 400-hall nursing unit on May 1, 2024, at 1:37 PM revealed Employee 7 (licensed practical nurse) preparing an intravenous solution of Cefazolin Sodium (liquid antibiotic), 2000 milligrams, for administration via Resident 74's PICC line (PICC, long, thin, tube that is inserted through a vein in the arm and passed through to a larger vein near the heart. The line requires careful care and monitoring for complications including bleeding, infection, and blood clots.). Continued observation of Employee 7 on May 1, 2024, at 1:43 PM revealed she administered 10 milliliters of normal sterile saline flush solution via Resident 74's PICC site before connecting the intravenous Cefazolin Sodium medication, which infused via an electrical pump. Employee 7 entered settings on the electrical pump to prompt administration of the medication over a one-hour period. The surveyor requested any intravenous or PICC line competencies or specialized trainings completed with Employee 7 during an interview with the Nursing Home Administrator and Director of Nursing on May 1, 2024, at 2:00 PM, and May 2, 2024, at 2:00 PM. Interview with the Director of Nursing and the Nursing Home Administrator on May 3, 2024, at 10:50 AM revealed that the facility had no evidence of any competencies or specialized trainings completed with Employee 7 pertaining to intravenous medication administration via a PICC line. 28 Pa. Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(a)(6)(d) Staff development 28 Pa. Code 211.12(d)(1) Nursing services