

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER Jersey Shore Skilled Nursing and Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 1008 Thompson Street Jersey Shore, PA 17740	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>38839</p> <p>Based on clinical record review, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding the implementation of physician-ordered recommendations regarding an oral medication for one of two residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>Clinical record review for Resident 1 revealed the resident has a diagnosis of hypercalcemia, (a condition in which the calcium level in the blood becomes too high), and hyperparathyroidism, (a condition that develops from too much activity in one or more parathyroid glands which boost the level of calcium in the bloodstream when needed), and these conditions were managed by the resident's endocrinologist.</p> <p>Further clinical record review for Resident 1 revealed a facility consultation form for Resident 1 from endocrinology dated March 27, 2023, noting the diagnosis of hypercalcemia, and hyperparathyroidism with recommendations to start Sensipar (cinacalcet, a medication used to treat high levels of calcium in the blood), 15 milligrams (mg) daily, and the resident was to return in three months. A copy of the prescription dated March 27, 2023, for Sensipar, 30 milligrams, take 0.5 tablets by mouth daily for 90 days, was observed in the resident's paper clinical record.</p> <p>A facility consultation form from endocrinology for Resident 1 dated June 27, 2023, noted to draw ionized calcium among multiple other lab work prior to a follow up appointment in two months. An after-visit summary from the June 27, 2023, visit noted instructions to continue Sensipar, schedule a two month follow up visit and obtain the noted lab work a few days prior to the appointment.</p> <p>Resident 1 was scheduled with a follow up appointment with endocrinology on August 28, 2023, and the requested lab work was ordered to be drawn on August 21, 2023.</p> <p>A review of Resident 1's medication orders revealed the Sensipar was ordered for the resident on March 20, 2023, after the March 27, 2023, endocrinology visit and was stopped after 90 days on June 28, 2023. There was no evidence the Sensipar was continued as instructed from the endocrinology visit on June 27, 2023.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's ionized calcium level obtained by lab on August 21, 2023, which was collected as recommended by endocrinology before the resident's scheduled appointment on August 28, 2023, revealed a level of 1.52 millimoles per liter (mmol/L), which was flagged as high from the reference range of 1.13-1.32 mmol/L. Resident 1's primary physician and endocrinology were made aware of the lab results with no new orders.</p> <p>Due to transportation issues, Resident 1's endocrinology appointment was cancelled on August 28, 2023, with rescheduled dates of August 30, and September 8, 2023, cancelled for the same reason. Resident 1 was then scheduled to see the endocrinologist on February 14, 2024.</p> <p>A nursing note dated October 10, 2023, at 2:16 PM noted the Resident 1's endocrinology appointment was scheduled for February 14, 2024, and labs were ordered for two days prior to the appointment. These labs included the ionized calcium level among the other labs that were also to be completed prior to the resident attending the appointment that was originally scheduled on August 28, 2023.</p> <p>A review of an ionized calcium level laboratory result collected on February 12, 2024, revealed a result of 1.60 mmol/L, which was flagged as critically high above the high end of the reference range of 1.13 - 1.32 mmol/L.</p> <p>A nursing note dated February 12, 2024, at 8:23 AM noted lab results with critical result for ionized calcium reported to doctor by message and email and order was obtained to send the resident to emergency department was received.</p> <p>A review of Resident 1's emergency room after visit summary dated February 12, 2024, it was noted to increase the resident's oral intake of water, and an extensive discussion with the resident's mother had taken place regarding the risk and benefit of intervention for the hypercalcemia (elevated ionized calcium level), in the emergency department and the mother wanted to avoid the discomfort of intravenous (IV, needle inserted into a vein), treatment and planned to follow up with the scheduled endocrinology appointment on February 14, 2024.</p> <p>Review of Resident 1's facility consultation report from endocrinology on February 14, 2024, it was noted to restart the Sensipar 15 mg, once daily, and to draw lab work on February 27, 2024, which included an ionized calcium level.</p> <p>Resident 1 was again ordered Sensipar 15 mg once daily on February 15, 2024.</p> <p>A review of Resident 1's ionized calcium level obtained by lab on February 27, 2024, after the medication was restarted, revealed a level of 1.34 mmol/L which remained high, but improved from the level obtained on February 12, 2024, and lower than the level of 1.52 mmol/L obtained on August 21, 2023. Resident 1 had not received the Sensipar, a medication used to control blood calcium levels, since it was stopped on June 28, 2023, and not continued as instructed upon the endocrinology visit on June 27, 2023.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 1 did experience an increase in the ionized calcium level upon lab work obtained prior to the scheduled August 28, 2023, endocrinology appointment that was cancelled. No other ionized calcium level was obtained until prior to the February 14, 2024, endocrinology appointment, after August 30, and September 8, 2023, appointments were cancelled by the facility. The Sensipar medication was then restarted after the February 14, 2024, appointment and based on repeated lab work of the ionized calcium has resulted in an improvement in the resident blood calcium level. There was no evidence endocrinology was aware the resident was not receiving the Sensipar from June 28, 2023, until the appointment on February 14, 2024.</p> <p>In an interview with the Director of Nursing on March 22, 2024, at 1:17 PM it was confirmed Resident 1 was not ordered to continue the Sensipar as instructed after the resident's endocrinology appointment on June 27, 2023, the resident had a high ionized calcium level on August 21, 2023, the resident missed appointments with endocrinology on August 28, 30, and September 8, 2023, had a critical high calcium level on February 12, 2024, requiring a visit to the emergency room , and upon visiting endocrinology on February 14, 2024, the Sensipar was restarted, and follow up lab work resulted in improvement in the resident's blood calcium level.</p> <p>Refer to 840</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839</p> <p>Based on clinical record review and resident and staff interview, it was determined that the facility failed to ensure that medically related social services were provided to one of two residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>In an interview with Resident 2 on [DATE], at 11:15 AM in the resident's room, Resident 2 stated she had resided in the room next door prior to the current room, and her roommate died . Resident 2 continued to say, She wasn't even that old, we had been talking, it was in the middle of the night, and I was up due to still having pain, then she was just gone. Resident 2 stated it was scary for her, she had never been in a nursing home, and after they all left, I knew she was gone. They pulled the curtain, and she was left in the room with her until later in the morning, when they came to take her out. Resident 2 indicated she was never approached by any staff to ask if she wanted to leave the room while her deceased roommate remained on the other side of the curtain, and again stated it was scary and uncomfortable for her.</p> <p>Resident 2 also stated in the interview that she thought this all had something to do with her room move, as they needed the room for someone who had to be alone, but they could tell I was freaked out because she died in there, as she wrinkled up her lips.</p> <p>Clinical record review for Resident 2 revealed the resident was admitted to the facility on [DATE], and was non-ambulatory due to due to fractures and injuries sustained from a fall prior to admission. Resident to was placed in a room with Resident CR1 upon admission on [DATE].</p> <p>Closed clinical record review for Resident CR1 revealed the resident expired at the facility on [DATE], while in the same room with Resident 2.</p> <p>Further review revealed Resident CR1's physician's discharge summary dated [DATE], at 2:58 PM, which noted the resident was pronounced on [DATE], at 3:58 AM, and it was reported that after a nurse evaluated the resident she was resting well, and when staff went back in to see her, she was not breathing and not responding.</p> <p>A nursing note dated [DATE], at 4:07 AM, for Resident CR1 noted at approximately 3:10 AM an aide entered the room to retrieve vital signs and discovered the resident was not breathing, and yelled for writer (licensed practical nurse, LPN), who quickly assessed and called the registered nurse, (RN). The resident was listed as full code, and the RN and LPN started Cardiopulmonary Resuscitation, (CPR), and while talking to the resident's first contact she stated if the resident was still being worked on to stop CPR, and the contact planned to inform them of the funeral home decision once she arrived in the morning.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note for Resident CR1 dated [DATE], at 4:10 AM noted the nurse was called to the resident's room and the resident was without pulse or respirations . Cardiopulmonary Resuscitation, (CPR), was started and 911 was called with one policeman and one Emergency Medical Technician, (EMT), arriving. It was noted CPR continued for 35 minutes, and the resident's power of attorney was called and indicated if the resident was not responding to stop everything.</p> <p>A note on [DATE], at 4:34 AM for Resident CR1 noted the time of death called at 3:58 AM.</p> <p>A note on [DATE], at 7:44 AM for Resident CR1 noted the funeral home was notified at 7:40 AM.</p> <p>A note on [DATE], at 9:06 AM for Resident CR1 noted the funeral home was at the facility at 8:20 AM to pick up the body.</p> <p>Resident 2 remained in the room with deceased Resident CR1 with the curtain pulled from 3:58 AM until the funeral home arrived at 8:20 AM. There was no evidence Resident 2 was provided any emotional support after the above incidents regarding her roommate requiring CPR, and expiring, or that Resident 2 was questioned about her desire to remain in the room with Resident CR1 deceased with the curtain pulled between them until the funeral home came to the facility to retrieve Resident CR1's body. Resident 2 was not able to independently move herself from the room.</p> <p>Clinical record review for Resident 2 did reveal she was moved to another room on [DATE], after CR1's body was already removed from the room. There was no documentation regarding the room move in Resident 2's clinical record. In an interview with the Director of Nursing on [DATE], she indicated the room move was due to arrival of an admission who needed a private room.</p> <p>As of [DATE], there was no evidence social services or any facility staff discussed the incident of Resident 2's roommate requiring CPR and expiring being witnessed by Resident 2, or how Resident 2 felt about remaining in the room with the deceased body.</p> <p>In an interview with the Director of Nursing on [DATE], at 12:18 PM, she indicated after a resident death, postmortem care is completed, and the curtain is pulled between residents, and she was not aware of any procedure to follow up with the roommate(s), as to wanting to remain in the room with the deceased body until the funeral home arrived.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>38839</p> <p>Based on clinical record review, and staff interview, it was determined that the facility failed to secure transportation for outside services for one of two residents reviewed for transportation needs (Resident 1).</p> <p>Findings include:</p> <p>Clinical record review for Resident 1 revealed the resident has a diagnosis of hypercalcemia, (a condition in which the calcium level in the blood become too high), and hyperparathyroidism, (a condition that develops from too much activity in one or more parathyroid glands which boost the level of calcium in the bloodstream when needed), and these conditions were managed by the resident's endocrinologist.</p> <p>A review of Resident 1's appointments with the endocrinology revealed the resident met with the endocrinologist on March 27, 2023, June 27, 2023, and was scheduled to meet again on August 28, 2023.</p> <p>A progress note for Resident 1 dated August 28, 2023, at 9:18 AM noted transportation was unable to take the resident to the appointment with endocrinology and it was rescheduled for August 30, 2023.</p> <p>A progress note for Resident 1 dated August 29, 2023, at 10:08 AM noted notification was received from the receptionist that transport was unable to take Resident 1 to the appointment scheduled for August 30, 2023, endocrinology was made aware, and an appointment was scheduled for September 8, 2023, at 1:30 PM.</p> <p>A progress note for Resident 1 dated September 8, 2023, at 9:12 AM noted the writer was informed by the receptionist that transportation for the day was rejected by the transport company and the resident's endocrinology appointment was cancelled.</p> <p>A progress note for Resident 1 dated October 10, 2023, at 2:16 PM, greater than one month after the last missed endocrinology appointment, noted an endocrinology appointment was scheduled for February 14, 2024, at 8:30 AM, nearly eight months since the last time the resident had seen the endocrinologist, and almost six months since the resident's August 2023, appointment was missed, and continued to be missed two more times due to transportation issues.</p> <p>In an interview with the Director of Nursing on March 22, 2024, at 1:15 PM, she indicated Resident 1 requires transportation via stretcher and transportation company utilized for that type of transfer cancelled on the facility and there was no backup. The Director of Nursing indicated the facility pays for the transportation for Resident 1 to appointments and confirmed the resident's endocrinology appointments were missed on August 28, 30, and September 8, until the resident finally attended the appointment on February 14, 2024.</p> <p>483.70 (g) Use of outside resources</p> <p>(continued on next page)</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Previously cited 5/11/23</p> <p>28 Pa. Code 201.21(c) Use of outside resources</p> <p>28 Pa. Code 211.12(d)(3) Nursing services</p>