

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Williamsport North Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Leader Drive Williamsport, PA 17701	

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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738</p> <p>Based on review of select facility policy and procedures, observations, and resident and staff interviews, it was determined that the facility failed to ensure that residents could make choices about aspects of their lives that were significant to them, such as smoking, for one of 25 residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>An interview with the Nursing Home Administrator (NHA) on May 20, 2024, at 8:22 AM revealed the facility was non-smoking. Smoking for residents was eliminated for new admissions beginning April 2023. However, there were three grandfathered residents that were still permitted to smoke. The NHA also reported that facility staff are permitted to smoke in a designated area, which is located on the facility property.</p> <p>The NHA indicated that the skilled nursing facility has a designated smoking area located outside of the main lobby for the grandfathered residents to smoke. Staff are permitted to smoke during break times in their designated area.</p> <p>Interview with Resident 1 on May 23, 2024, at 10:15 AM revealed that the resident does smoke but the facility indicated they are a non-smoking facility, so he is not able to smoke here. Resident 1 further indicated that it is unfair that others are allowed to smoke, and he is not, and this bothers the resident.</p> <p>The Nursing Home Administrator was made aware of Resident 1's concern related to smoking during a meeting on May 23, 2024, at 11:15 AM. The NHA confirmed that staff and the three grandfathered residents could smoke at the facility in designated areas, but that newly admitted residents are not allowed to smoke since they have switched to a non-smoking facility. They also confirmed that residents are made aware of this on admission and stated Resident 1 signed a non-smoking agreement on admission.</p> <p>Clinical record review for Resident 1 revealed documentation that the resident was admitted to the facility on [DATE], at 2:22 PM. The documentation further noted the resident is a tobacco user.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Social Services documentation for Resident 1 dated May 3, 2024, at 3:23 PM revealed that social services and the registered nurse unit manager explained the non-smoking policy and the other residents that Resident 1 sees outside smoking were grandfathered in. The documentation further noted that per the NHA, the resident would be permitted to smoke if he was off the facility property.</p> <p>The facility failed to promote and facilitate resident self-determination through support of resident choice by not allowing the resident to smoke due to a non-smoking facility; however, allowing the facility staff to smoke in designated areas on the facility property.</p> <p>28 Pa. Code 201.29(a) Resident rights</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29512</p> <p>Based on observation and resident and staff interview, it was determined that the facility failed to provide adequate housekeeping and maintenance services to ensure a clean, safe, and orderly environment on two of three nursing units (2nd and 3rd Floor Nursing Unit, Residents 56 and 60) and ensure properly functioning of resident equipment for one of 25 residents (Resident 1).</p> <p>Findings include:</p> <p>Interview with Resident 56 on May 20, 2024, at 10:27 AM revealed that she indicated concerns with her bathroom environment, noting the toilet was dirty and the floor was black. Resident 60 stated that she was independent with her care and wears a brief due to incontinence. She indicated concerns with the hem/bottom of her pants becoming soiled from the condition of the bathroom.</p> <p>Observation of Resident 56's bathroom on May 20, 2024, at 10:37 AM confirmed her statement. The floor around the base of the toilet was stained that extended four inches out on the floor from the toilet. Inside the toilet bowl, there were brown stains and material similar to feces. The bathroom smelled strongly of urine and a [NAME], musty smell.</p> <p>The surveyor reviewed the above information during an interview with the Nursing Home Administrator and Director of Nursing on May 21, 2024, at 3:15 PM.</p> <p>Observation of Resident 60's room on May 21, 2024, at 11:54 AM revealed the wall under the window was patched but not painted, there were holes in the wall under the vent that was located to the right (when looking at it) of Resident 60's dresser, and the wall between the two dressers in the room was marred.</p> <p>The Nursing Home Administrator and the Director of Nursing were made aware of the environmental concerns in Resident 60's room in a meeting on May 21, 2024, at 3:00 PM.</p> <p>An interview with Resident 1 on May 23, 2024, at 10:15 AM revealed that the resident had concerns related to the facility's bladder scanner (a non-invasive medical device that utilizes an ultrasound probe to measure the amount of urine in the bladder). Resident 1 indicated the bladder scanner is broken and the resident is supposed to be bladder scanned.</p> <p>Clinical record review for Resident 1 revealed a current physician's order dated April 29, 2024, that instructed staff to bladder scan the resident five times a day as scheduled; if results are of 400 cubic centimeters (cc) straight catheterize (utilize a sterile catheter that is inserted into the bladder to drain urine) five times a day; DO NOT CHANGE TIMES PER THE PHYSICIAN ASSISTANT.</p> <p>An interview with an anonymous staff member on May 23, 2024, at 10:55 AM revealed that the bladder scanner has been broken for months but could not specify an exact time period. The staff member further noted the probe to the bladder scanner was cracked and the accuracy of the device was questionable. This was reported many times to supervisory personnel including the Director of Nursing according to the staff member.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of the bladder scanner on May 23, 2024, at 10:59 AM revealed a large C-shaped crack at the tip of the probe (the part of the bladder scanner used to scan the bladder for urine) that was slightly indented. The probe had a sticky yellow substance accumulated on a section of it. There was a blue colored Preventative Maintenance Inspection sticker on the back of the bladder scanner main display unit with the last three dates marked as: 6/21, 6/27/20, and 6/28/19. The owner's manual and quick start guide was located in a plastic basket attached to the device and both were covered in a sticky, yellow substance with debris noted stuck to the manual.</p> <p>Review of the Owner's Manual for the bladder scanner revealed on page 12 a section that noted start-up and shutdown of the device. The probe connection section noted: Check to be certain the probe is properly connected, is not leaking fluid and is not damaged. Verify that the probe head surface and probe cable are in good condition.</p> <p>Further review of the Owner's Manual for the bladder scanner revealed a section of recommended usage, warnings and troubleshooting located on page 37 that noted to, Take special care to avoid physical shock and vibration when moving the device. Be especially careful when handling or transporting the probe, which contains especially sensitive components. Page 39 of the manual noted: Avoid scratching the surface of the probe during use, charging, or transportation. If the probe is dropped, verify there is no visual damage and test it for proper function. If the probe is broken, please stop using it immediately and contact the company for repair/replacement. Replace the probe immediately if it is damaged or broken.</p> <p>Nursing documentation for Resident 1 revealed the following:</p> <p>April 28, 2024, at 2:07 PM: Staff attempted to use the bladder scanner however, it is not turning on or in operating condition.</p> <p>April 30, 2024, at 5:07 AM: Bladder scanner reading was zero and may be due to a large crack in the transmitter. The registered nurse (RN) supervisor was made aware per the documentation.</p> <p>May 2, 2024, at 10:56 AM: Attempted to use bladder scanner and was reading zero.</p> <p>May 6, 2024, at 2:16 AM: Staff unable to bladder scan due to a non-functioning scanner.</p> <p>May 6, 2024, at 5:57 PM: Staff noted the bladder scanner not working.</p> <p>May 8, 2024, at 7:33 PM: Staff noted the bladder scanner is not functioning.</p> <p>May 8, 2024, at 10:26 PM: Staff noted the bladder scanner is broken.</p> <p>May 8, 2024, at 10:30 PM: Staff noted they are unable to bladder scan the resident due to the machine being broken.</p> <p>May 9, 2024, at 5:09 AM, 5:48 AM, and 5:49 AM: Staff noted unable to bladder scan the resident due to the machine being broken.</p> <p>May 14, 2024, at 1:30 AM: Staff noted the bladder scanner does not work.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>May 14, 2024, at 5:01 AM: Staff noted the bladder scanner is broken.</p> <p>May 22, 2024, at 10:17 PM: Staff noted unable to bladder scan due to machine being broken and does not work.</p> <p>May 23, 2024, at 3:35 AM: Staff noted the bladder scanner does not work.</p> <p>Further clinical record review for Resident 1 revealed that there was no documentation that indicated the physician was aware the bladder scanner was damaged or not working as indicated by staff.</p> <p>An interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on May 23, 2024, at 11:08 AM revealed that the facility was aware the bladder scanner probe was broken. The DON indicated there was only one bladder scanner in the facility. They were unsure how long the machine was broken and would have to check. They indicated that the company was contacted to repair it; however, it was unclear when this was done and would also have to check.</p> <p>Further questioning with the NHA and DON on May 23, 2024, at 1:08 PM and 2:00 PM regarding the date the bladder scanner repair was requested or any documentation to support this revealed no further information provided by the facility. The NHA further noted that maybe corporate would know. No documentation or date was ever provided to the surveyor regarding information related to the requested repair of the device, obtaining a replacement part, or getting a loaner device to use in the interim.</p> <p>483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment</p> <p>Previously cited 8/1/23 and 6/16/23</p> <p>28 Pa. Code 201.18(b)(3) Management</p> <p>28 Pa. Code 207.2(a) Administrator's responsibility</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>36798</p> <p>Based on clinical record review, review of facility documents, and resident and staff interview, it was determined that the facility failed to protect a resident to be free from neglect by not providing the services necessary to avoid physical harm resulting in injury for one of two residents reviewed (Resident 60).</p> <p>Findings include:</p> <p>Clinical record review for Resident 60 revealed a progress note dated April 19, 2024, at 11:00 AM that indicated she had a fall in her room. Staff members heard her yelling, entered her room, and observed her on the floor between the beds in the room. She was in a prone position, facing the wall. Blood was noted on the floor near her head. Her walker was in an upright position near her. A laceration was noted to the right side of her head just above her ear and measured 5.0 centimeters x 3.0 centimeters x 1.0 centimeters. Pressure was applied to the laceration. The Physician Assistant was notified and ordered staff to send the resident to the emergency room .</p> <p>Further clinical record review for Resident 60 revealed a progress note dated April 19, 2024, at 6:10 PM that indicated Resident 60 returned from the emergency room at 3:55 PM. She had a dressing on the head laceration. It was noted that she received seven sutures to the head laceration. She was ordered Keflex (an antibiotic to prevent infection) 500 mg four times a day for seven days.</p> <p>Interview with Resident 60 on May 21, 2024, at 11:54 AM revealed that she got up out of the stationary chair with her walker, and walked around the bottom of her bed, to the other side, to reach her call bell that was on the bed near the top of the bed. She stated that she wanted to talk to someone from the business office and needed her call bell. She took her hand off her walker to get the call bell, pushed the button, and as she was standing back up to get her walker, she lost her balance, and fell backwards to the floor.</p> <p>A witness statement provided by Employee 2, physical therapist, dated April 19, 2024, indicated that she provided therapy in her room. Employee 2 ambulated her to the door and back with her walker and supervision. Then she sat her in a straight back chair at the end of her bed and completed exercises. When she was done, Resident 60 remained in the chair with her over bed table placed in front of her. Employee 2 indicated that she was told by a nurse aide (no name provided) to have the resident sit in the chair at the end of the bed instead of her wheelchair because it was her choice. Her statement indicated that she instructed Resident 60 not to get up on her own and that she stretched the call bell across the bed as far as possible.</p> <p>Employee 2 placed Resident 60 in a stationary chair, in her room, then left the room without providing Resident 60 with a way to contact staff if she needed them. Employee 2 failed to alert nursing staff that she left Resident 60 in the stationary chair and that her call bell was not in reach.</p> <p>Review of Resident 60's care plan for fall risk that was implemented on April 12, 2024, and revised on April 15, 2024, revealed an intervention for staff to make sure her call light was within reach and encourage her to use it for assistance as needed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employee 2 was re-educated on making sure the call bell was in reach on April 22, 2024.</p> <p>Interview with the Nursing Home Administrator on May 23, 2024, at 11:00 AM revealed that the facility only educated Employee 2 and three other employees from the therapy department, and that they did not educate other staff that would be responsible for fall prevention and following care plans, to prevent this from reoccurring.</p> <p>The above findings were reviewed during an interview with the Nursing Home Administrator and Director of Nursing on May 23, 2024, at 11:30 AM.</p> <p>The facility failed to prevent neglect that resulted in injury for Resident 60.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to notify a resident and/or the resident's responsible party in writing of a transfer to the hospital for 5 of 11 residents reviewed (Residents 6, 64, 112, 19, and 126). The facility also failed to notify the Office of the State Long-Term Care Ombudsman of a transfer to the hospital for 4 of 11 residents reviewed (Residents 6, 64, 126, and 112).</p> <p>Findings include:</p> <p>A review of Resident 6's clinical record revealed that the facility transferred him to the hospital from April 18 to 19, 2024. There was no documented evidence to indicate that the facility provided a written notice to Resident 6's responsible party regarding his transfer to the hospital that included the required contents: reason for the transfer, effective date of the transfer, location to which the resident was transferred to, contact and address (mailing and email) information for the Office of the State Long-Term Care Ombudsman, and information (mailing and email address and telephone number) for the agency responsible for the protection and advocacy of individuals with developmental disabilities, and a statement of resident's appeal rights, including name, address (mailing and email) and telephone number of entity which receives requests. Further review of facility documentation revealed there was no documented evidence that the facility notified the Office of the State Long-Term Care Ombudsman of Resident 6's transfer to the hospital.</p> <p>Clinical record review for Resident 64 revealed she was transferred to the hospital from February 15 to 16, 2024. There was no evidence to indicate that Resident 64's responsible party was provided written notification to include the above-required contents. Further review of facility documentation revealed there was no documented evidence that the facility notified the Office of the State Long-Term Care Ombudsman of Resident 64's transfer to the hospital.</p> <p>Clinical record review for Resident 112 revealed he was transferred to the hospital from January 30 to 31, 2024. There was no evidence to indicate that Resident 112's responsible party was provided written notification to include the above-required contents. Further review of facility documentation revealed there was no documented evidence that the facility notified the Office of the State Long-Term Care Ombudsman of Resident 112's transfer to the hospital.</p> <p>Clinical record review for Resident 19 revealed he was transferred to the hospital from May 13-17, 2024. There was no evidence to indicate that Resident 19 or his responsible party were provided written notification to include the above noted required contents related to his transfer out to the hospital.</p> <p>Closed clinical record review revealed that Resident 126 went out to the hospital on March 3, 2024, related to a change in mental status. There was no evidence to indicate that Resident 126 or her responsible party were provided with written notification related to her transfer out to the hospital. Further review of facility documentation revealed there was no documented evidence that the facility provided the Office of the State Long-Term Care Ombudsman of Resident 126's transfer to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>The Nursing Home Administrator confirmed the above noted findings regarding transfer notices for Residents 6, 19, 64, 112, and 126 during an interview on May 22, 2024, at 11:08 AM.</p> <p>483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/discharge</p> <p>Previously cited 06/16/23</p> <p>28 Pa. Code 201.14(a) Responsibility of license</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>36798</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident or resident representative received written notice of the facility's bed hold policy at the time of transfer for two of 11 residents reviewed for hospitalization s (Residents 19 and 126).</p> <p>Findings include:</p> <p>Clinical record review for Resident 19 revealed he was transferred to the hospital from May 13-17, 2024. There was no evidence to indicate that Resident 19 or his responsible party were provided written notification of the facilities bed hold policy at the time of his transfer out of the facility.</p> <p>A closed clinical record review revealed that Resident 126 went out to the hospital on March 3, 2024, related to a change in mental status. There was no evidence to indicate that Resident 126 or her responsible party were provided with written notification of the facilities bed hold policy at the time of her transfer.</p> <p>The facility failed to provide written notice of their bed hold policy at the time of transfer for Residents 19 and 126.</p> <p>The Nursing Home Administrator confirmed the above-noted findings related to bed hold notices during a meeting on May 23, 2024, at 12:10 PM.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>29512</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered weights, medications, and vital signs for four of 25 residents (Resident 3, 41, 67, and 88).</p> <p>Findings include:</p> <p>Review of Resident 3's clinical documentation revealed current physician orders for the following:</p> <p>On September 11, 2023, staff were to complete a daily weight every night shift and must be done before breakfast. Staff were to contact the physician if the weight dropped below 320 pounds.</p> <p>On March 19, 2024, call the physician if their weight changes two to three pounds in one day or five pounds in one week, every day and evening shift for monitoring.</p> <p>Review of Resident 3's clinical documentation revealed no documented weights on the following dates:</p> <p>February 23, 2024</p> <p>February 24, 2024</p> <p>May 21, 2024</p> <p>Further review of Resident 3's clinical documentation revealed that there was no physician notification regarding their weight being below 320 pounds on the following dates:</p> <p>April 23, 24, 25, 26, 27, 28, and 29, 2024</p> <p>May 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18, 2024</p> <p>Further review of Resident 3's clinical documentation revealed that there was no physician notification regarding their weight change of two to three pounds in a day or a five pounds in one week on the following dates:</p> <p>March 21, 2024, 321.5 pounds to March 22, 2024, 325.5 pounds, 4-pound increase</p> <p>March 27, 2024, 324.0 pounds to March 28, 2024, 327.0, 3-pound increase</p> <p>March 28, 2024, 327.0 pounds to March 29, 2024, 323.0 pounds, 4-pound decrease</p> <p>March 29, 2024, 323.0 pounds to March 30, 2024, 326.5 pounds, 3.5-pound increase</p> <p>April 5, 2024, 325.0 pounds to April 6, 2024, 321.8 pounds, 3.2-pound decrease</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 - Some</p>	<p>April 9, 2024, 321.0 pounds to April 10, 2024, 324.0 pounds, 3-pound decrease</p> <p>April 10, 2024, 324.0 pounds to April 11, 2024, 337.0 pounds, 13-pound increase</p> <p>April 22, 2024, 320.5 pounds to April 23, 2024, 315.8 pounds, 4.7-pound decrease</p> <p>April 27, 2024, 315.0 pounds to April 28, 2024, 317.5 pounds, 2.5-pound increase</p> <p>April 29, 2024, 316.8 pounds to April 30, 2024, 320.0 pounds, 3.2-pounds increase</p> <p>May 6, 2024, 319.5 pounds to May 7, 2024, 316.5 pounds, 3-pound decrease</p> <p>May 12, 2024, 317.5 pounds to May 13, 2024, 319.8 pounds, 2.3-pound increase</p> <p>May 17, 2024, 314.0 pounds, to May 18, 2024, 318.0 pounds, 4-pound increase</p> <p>Clinical record review for Resident 41 revealed the following physician orders:</p> <p>On November 29, 2023, for staff to monitor their blood sugar twice daily (BID) and notify the provider if it was less than 80 mg/dL or greater than 300 mg/dL (milligrams/deciliter).</p> <p>On April 3, 2024, Lantus (insulin) 100 units/milliliter (u/ml) inject 66 units subcutaneously (SQ) at bedtime (HS) for Diabetes. HOLD Lantus if (Resident 41's) blood sugar was less than 120 milligrams/deciliter (mg/dL)</p> <p>Review of Resident 41's clinical documentation revealed the following:</p> <p>On March 24, 2024, at 9:00 PM, their blood sugar was not documented.</p> <p>On March 26, 2024, at 6:00 AM, their blood sugar was not documented.</p> <p>On March 29, 2024, at 9:00 PM, their blood sugar was 40 mg/dL.</p> <p>On March 31, 2024, at 6:00 AM, their blood sugar was not documented.</p> <p>On April 11, 2024, at 6:00 AM, their blood sugar was not documented.</p> <p>On April 15, 2024, at 6:00 AM, their blood sugar was not documented.</p> <p>On April 16, 2024, at 6:00 AM, their blood sugar was 78 mg/dL.</p> <p>On April 17, 2024, at 6:00 AM, their blood sugar was 79 mg/dL.</p> <p>On April 23, 2024, at 6:00 AM, their blood sugar was not documented.</p> <p>On April 29, 2024, at 6:00 AM, their blood sugar was 77 mg/dL.</p> <p>On April 30, 2024, at 6:00 AM, their blood sugar was 112 mg/dL.</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 - Some</p>	<p>On May 3, 2024, at 6:00 AM, their blood sugar was not documented.</p> <p>On May 8, 2024, at 9:00 PM, their blood sugar was 106 mg/dL. Staff administered 66 units of Lantus though the order indicated to hold if Resident 41's blood sugar was less than 120 mm/dL.</p> <p>On May 9, 2024, at 9:00 PM, their blood sugar was 88 mg/dL. Staff administered 66 units of Lantus though the order indicated to hold if Resident 41's blood sugar was less than 120 mm/dL.</p> <p>On May 16, 2024, at 6:00 AM, their blood sugar was 78 mg/dL.</p> <p>On May 16, 2024, at 9:00 PM, their blood sugar was 118 mg/dL. Staff administered 66 units of Lantus though the order indicated to hold if Resident 41's blood sugar was less than 120 mm/dL.</p> <p>On May 21, 2024, at 6:00 AM, their blood sugar was 72 mg/dL.</p> <p>There was no documentation indicating that staff notified Resident 3's physician regarding their weight as ordered or Resident 41's blood sugar levels being outside of the prescribed parameters prior to surveyor identification.</p> <p>The surveyor reviewed the above information during an interview on May 22, 2024, 3:00 PM with the Nursing Home Administrator and Director of Nursing.</p> <p>Clinical record review for Resident 88 revealed a current care plan that revealed the resident has constipation related to decreased mobility, diminished appetite, poor fiber intake, and poor fluid intake. Some interventions included the following: follow facility bowel protocol for bowel management and record bowel movement pattern each day and describe the amount, color, and consistency.</p> <p>Clinical record review for Resident 88 revealed the following physician orders to promote bowel movements:</p> <p>Gavilax Powder (Polyethylene Glycol 3350, medication used to treat constipation) give 17 grams by mouth as needed for day three with no bowel movement.</p> <p>Enulose Solution 10 grams per 15 ml (a medication used to treat constipation) give 45 ml by mouth every 96 hours as needed for day four with no bowel movement.</p> <p>Dulcolax suppository (Bisacodyl, a laxative medication used to relieve constipation) insert 10 milligrams rectally as needed for day five with no bowel movement.</p> <p>Review of bowel elimination records for Resident 88 revealed that staff documented no bowel movements for May 15, 16, 17, 18, and 19, 2024.</p> <p>There was no indication that staff offered (as per the physician orders and bowel management protocol), or Resident 88 refused, any PRN medications.</p> <p>The above information for Resident 88 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on May 22, 2024, at 2:00 PM.</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 - Some</p>	<p>Clinical record review for Resident 67 revealed a nurse practitioner progress note dated December 6, 2023, at 9:42 AM that indicated the resident was evaluated for hypotension (low blood pressure). The diagnosis was documented as hypotension and the treatment and plan of care included vital signs for three days.</p> <p>A review of the vital signs flow sheet for resident 67 revealed the resident had a blood pressure taken on December 5, 2023, at 4:10 PM that noted a low blood pressure. The next set of vital signs was not taken until December 15, 2023, at 10:40 AM.</p> <p>Facility documentation for Resident 67 revealed a Physician/Provider Update form that had a written order signed by the medical provider and a licensed practical nurse and dated December 6, 2023, that indicated VS x3 days (vital signs for three days).</p> <p>Facility documentation for Resident 67 revealed another Physician/Provider Update form dated December 15, 2023, that noted previously ordered and not completed. The order again noted VS x3 days (vital signs for three days).</p> <p>Further review of the medical record for Resident 67 revealed no further evidence that the vital signs requested on December 6, 2023, were completed until December 15, 2023.</p> <p>An interview with the Director of Nursing on May 23, 2024, at 10:09 AM revealed that the vital signs were not entered into the electronic health record (EHR) of Resident 67 as an order, so they were not completed.</p> <p>The above information for Resident 67 was reviewed with the Nursing Home Administrator on May 23, 2024, at 2:00 PM.</p> <p>483.25 Quality of Care</p> <p>Previously cited 6/16/23</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>44738</p> <p>Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to obtain proper treatment and assistive devices to maintain vision for one of one resident reviewed (Resident 46).</p> <p>Findings include:</p> <p>An interview with Resident 46 on May 20, 2024, at 11:00 AM revealed the resident was at the eye doctor last year and was told she needed eyeglasses but has not received the eyeglasses. The resident further reported she utilizes readers, which help her see up close, but has trouble viewing the television because it is blurred.</p> <p>An optometry evaluation dated June 1, 2023, revealed that Resident 46 was seen by optometry for a new facility ordered vision consultation. The evaluation further indicated on the form to Circle all that applies if dispensed or ordered any glasses or frames. SPH (sphere) BF (bifocal) was circled under the Frames section. The form also noted for the resident to follow-up in six months.</p> <p>A Care Plan Note dated August 28, 2023, at 5:38 PM revealed Resident 46 asked about the delivery of her glasses ordered on June 1, 2023. The documentation further noted a voicemail was left to inquire about the eyeglasses.</p> <p>Further clinical review for Resident 46 revealed no further documentation regarding the resident's eyeglasses, or evidence that the resident had a follow-up visit in six months as requested during the initial visit, or documentation to indicate the resident refused the eyeglasses or follow-up visit.</p> <p>An interview with the Nursing Home Administrator on May 23, 2024, at 9:06 AM revealed that the glasses were supposedly sent to the facility. However, the facility is unable to locate them, so a new pair was ordered.</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 - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>18229</p> <p>Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to assess and implement treatment and services to prevent the development and promote the healing of a pressure ulcers for one of three residents reviewed for pressure ulcer concerns (Resident 64).</p> <p>Findings include:</p> <p>The facility policy entitled Skin Integrity, last reviewed without changes on May 4, 2024, revealed residents will be assessed/observed for risk of skin breakdown, utilizing the Braden scale within 24 hours of admission, quarterly, and as necessitated by a residents change in condition. Wound status is monitored on a weekly basis. The interdisciplinary plan of care will address problems, goals, and interventions directed toward the prevention of pressure injuries and/or skin integrity concerns identified. If identified risk is present the interventions will be documented in the baseline plan of care and/or comprehensive care plan. If there is a decline in skin integrity pressure redistribution surfaces will be reviewed and interventions and plan of care updated as appropriate. Residents will be observed during care by nurse aides daily for reddened/open areas. Changes will be reported to the licensed nurse and documented. If identified at risk or with actual alterations in the skin integrity of feet, footwear will be addressed for appropriateness.</p> <p>Clinical record review revealed the facility admitted Resident 64 on July 9, 2021.</p> <p>A review of a skin check completed by a licensed practical nurse on January 9, 2024, noted Resident 64's ankle was red and Resident 64 was complaining of it hurting. The licensed practical nurse noted that a new treatment was started.</p> <p>A review of Resident 64's Treatment Administration Record (TAR, a form utilized to document the administration of resident treatments) dated January 2024 revealed there were no new treatment orders for Resident 64's ankle. An interview with the Director of Nursing on May 23, 2024, at 12:27 PM confirmed these findings.</p> <p>Further review of Resident 64's clinical record revealed an integrated wound care note on January 9, 2024, noting Resident 64 was being seen for evaluation and treatment recommendations regarding a pressure ulcer to her right ankle from home. The wound care note indicated Resident 64 has had the pressure area for a while (unsure how long) and it recently worsened gradually. Wound care assessed Resident 64's pressure ulcer to her right lateral ankle as a Stage 3 (full thickness tissue loss, subcutaneous fat may be visible), measuring 0.5 centimeters (cm) by 0.5 cm by 0.1 cm.</p> <p>A review of Resident 64's clinical record revealed the last Braden assessment (a standardized, evidence-based assessment tool that helps predict a patient's risk of developing a pressure injury) before identification of Resident 64's pressure injury on January 9, 2024, was August 16, 2023, noting Resident 64 was at risk of developing a pressure ulcer. Further review of Resident 64's Braden assessments revealed Employee 5 (registered nurse) started a Braden assessment on January 4, 2024, noting Resident 64 was low risk, but did not sign off on the Braden assessment until January 11, 2024, (after identified Stage 3 pressure ulcer).</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 - Few</p>	<p>Review of Resident 64's physician assistant progress note dated January 15, 2024, revealed Resident 64 was seen for a follow-up on the integrated wound visit. The physician assistant noted Resident 64 has had a pressure ulcer on her right ankle for an unspecified duration, which recently worsened.</p> <p>A review of Resident 64's plan of care revealed the facility did not initiate a plan of care to address Resident 64's new pressure ulcer until February 26, 2024, (7 weeks after identification of the pressure area).</p> <p>The surveyor attempted to observe Resident 64's ankle on May 23, 2024, at 11:47 AM, and Resident 64 refused.</p> <p>The facility did not assess and implement interventions timely to address the pressure area identified on Resident 64's right ankle on January 9, 2024.</p> <p>Interview with the Director of Nursing on May 23, 2024, at 12:53 PM confirmed these findings. She could provide no further documentation that the facility assessed and implemented interventions to address Resident 64's identified pressure ulcer since January 15, 2024.</p> <p>28 Pa. Code 211.10(d) Resident care policies</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>29512</p> <p>Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide services to maintain a resident's range of motion (ROM) for two of nine residents reviewed (Residents 28 and 56).</p> <p>Findings include:</p> <p>Clinical record review for Resident 28 revealed a current care plan for staff to provide a restorative program related to immobility including the following:</p> <p>ROM (range of motion, movement of the body to maintain a resident's ability) supine and seated exercised to their BLLE (bilateral lower extremities)</p> <p>AROM (active range of motion, AAROM (active assisted range of motion) and/or PROM (passive and BLUE (bilateral upper extremities) to maintain SBA (stand by assistance) sideboard transfer bed to wheelchair and/or wheelchair to bed and maintain current BLLE strength</p> <p>Restorative transfer and OOB (out of bed) program to be OOB for at least one hour each day to build and/or maintain core strengthening.</p> <p>Restorative OOB daily. Refer to therapy if change in current level of function (CLOF).</p> <p>Review of task documentation for Resident 28 for March, April, and May 2024, revealed that staff did not document completion of the restorative task on the following dates:</p> <p>For ROM supine and seated exercised to their BLLE:</p> <p>March 22, 2024, day shift (no documentation)</p> <p>March 19, 20, 25, 29, and 30, 2024, day shift (documented not applicable)</p> <p>April 7, 14, 18, and 24, 2024, day shift (no documentation)</p> <p>April 17, 23, and 27, 2024, day shift (documented not applicable)</p> <p>May 6, 11, and 12, 2024, day shift (no documentation)</p> <p>May 2, 7, 15, and 16, 2024, day shift (documented not applicable)</p> <p>For AROM/AAROM/PROM for sideboard transfer from bed to wheelchair/wheelchair to bed:</p> <p>March 3 and 22, 2024, day shift (no documentation)</p> <p>March 5, 6, 25, 29, and 30, 2024, day shift (documented not applicable)</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>March 3, 10, 22, and 23, 2024, evening shift (no documentation)</p> <p>March 5, 6, 14, 19, 24, and 31, 2024, evening shift (documented not applicable)</p> <p>April 3 and 22, 2024, day shift (no documentation)</p> <p>April 5 and 6, 2024, day shift (documented not applicable)</p> <p>April 3 and 22, 2024, evening shift (no documentation)</p> <p>April 5 and 6, 2024, evening shift (documented not applicable)</p> <p>May 6, 11, and 12, 2024, day shift (no documentation)</p> <p>May 2, 7, 15, and 16, 2024, day shift (documented not applicable)</p> <p>May 2, 5, 7, and 18, 2024, evening shift (no documentation)</p> <p>May 9 and 11, 2024, evening shift (documented not applicable)</p> <p>Restorative transfer and OOB program to be OOB for at least one hour each day to build and/or maintain core strengthening.</p> <p>March 3 and 22, 2024, day shift (no documentation)</p> <p>March 2, 5, 14, 20, and 25, 2024, day shift (documented not applicable)</p> <p>April 7, 14, 18, and 24, 2024, day shift (no documentation)</p> <p>April 4, 6, 16, 17, 21, 23 and 27, 2024, day shift (documented not applicable)</p> <p>May 6, 11, and 12, 2024, day shift (no documentation)</p> <p>Restorative OOB daily. Refer to therapy if change in CLOF.</p> <p>March 22, 2024, day shift (no documentation)</p> <p>March 5 and 20, 2024, day shift (documented not applicable)</p> <p>April 7, 14, 18, and 24, 2024, day shift (no documentation)</p> <p>April 23 and 27, 2024, day shift (documented not applicable)</p> <p>May 6, 11, and 12, 2024, day shift (no documentation)</p> <p>May 2, 2024, day shift (documented not applicable)</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>Staff documented frequent refusals by Resident 28 throughout March, April, and May 2024 to get OOB. There was no facility documentation that identified this CLOF or notification to therapy.</p> <p>Clinical record review for Resident 56 revealed a current care plan for staff to provide restorative nursing for AROM to maintain BLLE strength to decrease the risk for falls.</p> <p>Review of task documentation for Resident 56 for March, April, and May 2024, revealed that staff did not document completion of the restorative task on the following dates:</p> <p>March 19, 20, 21, 23, 24, 27, 28, 29, and 31, 2024, day shift (documented resident refusal of services by one specific employee)</p> <p>March 26, 2024, day shift (documented not applicable)</p> <p>March 28, 2024, evening shift (no documentation)</p> <p>March 24, 2024, evening shift (documented not applicable)</p> <p>April 1, 2, 3, 4, 6, 7, 9, 10, 11, 12, 15, 16, 17, 18, 19, 20, 21, 23, 24, 25, 26, 29, and 30, 2024, day shift (documented resident refusal of services by one specific employee)</p> <p>April 5, 2024, day shift (no documentation)</p> <p>April 13, 14, 22, and 28, 2024, day shift (documented not applicable)</p> <p>April 2, 11, and 25, 2024, evening shift (documented not applicable)</p> <p>May 1, 2, 4, 5, 7, 9, 10, 13, 14, 15, 16, 18, and 19, 2024, day shift (documented resident refusal of services by one specific employee)</p> <p>May 5, 2024, evening shift (no documentation)</p> <p>May 18, 2024, evening shift (documented not applicable)</p> <p>Further review of Resident 56's task documentation revealed that she usually accepts staff assistance as needed for care and services.</p> <p>Interview with Resident 56 on May 20, 2024, at 10:27 AM revealed that she indicated she was independent with her care (including ambulation to the bathroom). She did not indicate refusals of her restorative program services from staff.</p> <p>The surveyor reviewed the above information on May 22, 2024, at 2:57 PM with the Nursing Home Administrator and Director of Nursing.</p> <p>28 Pa. Code 211.10(a)(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>18229</p> <p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to implement interventions to promote acceptable parameters of nutrition for one of nine residents reviewed (Resident 64).</p> <p>Findings include:</p> <p>The facility Weight Policy, last reviewed without changes on May 4, 2024, revealed any resident with weight changes of five or more pounds will be re-weighed within 24 hours post the original weight. The dietitian will review the medical record of any resident with significant weight changes (greater than/equal to five percent in one month, greater than/equal to seven and a half percent in three months, and greater than/equal to 10 percent in six months). Interventions will be recommended, as needed. The nurse will confirm with the physician any order recommendations made by the dietitian. Interventions that are initiated in response to a weight change will be reflected in the residents care plan. Residents with significant weight loss/ gain will be further reviewed by the interdisciplinary team meetings. The charge nurse will notify the resident and/or resident representative of weight and order changes.</p> <p>Clinical record review revealed the facility admitted Resident 64 on July 9, 2021. Further review of Resident 64's clinical record revealed the following weight assessments:</p> <p>December 6, 2023, 86.0 pounds</p> <p>January 3, 2024, 106.0 pounds (a 20-pound, 23.26 percent severe weight gain)</p> <p>January 9, 2024, 107.2 pounds</p> <p>January 16, 2024, 93.0 pounds (a 14.2-pound, 13.25 percent severe weight loss)</p> <p>Further review of Resident 64's clinical record revealed a weight change note dated January 16, 2024, noting significant weight loss and gain. The note revealed Resident 64's medications do not include any diuretics or appetite enhancing medications. Employee 3 (registered dietitian) had no new recommendations at this time.</p> <p>An interview with Employee 3 on May 23, 2024, at 11:38 AM confirmed the above findings. She confirmed Resident 64's re-weight was not completed for seven days after her January 3, 2024, severe weight gain. Employee 3 confirmed there was no indication that the facility assessed Resident 64's severe weight gain or notified Resident 64's physician and responsible party.</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>29512</p> <p>Based on review of facility policies, clinical record review, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered pain medications for four of four residents reviewed (Residents 3, 56, 96, and 123).</p> <p>Findings include:</p> <p>Review of Physiopedia's and Wikipedia's definition of the numeric pain rating scale (parameters) from zero to 10 indicated that no pain was identified as zero, mild pain was identified as one to three, moderate pain was identified as four to six, and severe pain was identified as seven to 10.</p> <p>Clinical record review for Resident 3 revealed physician orders for the following pain medications:</p> <p>Ordered on April 19, 2024, Acetaminophen (Tylenol, for mild pain) 325 milligrams (mg) 2 tablets by mouth (PO) every 4 hours as needed (PRN) for pain 1-10, not to exceed 3 grams per 24 hours.</p> <p>Ordered on May 2, 2024, Oxycodone (for moderate to severe pain) 5 mg PO every 8 hours PRN for pancreatic pain.</p> <p>There was no documentation that the facility identified which pain medication that staff were to administer for mild, moderate, and/or severe pain parameters, or that the facility identified that multiple medications were available for the same pain parameter.</p> <p>Clinical record review for Resident 56 revealed physician orders for the following pain medications:</p> <p>Ordered on October 19, 2023, Acetaminophen 650 mg PO every 6 hours PRN for arthritic pain.</p> <p>Ordered on March 4, 2024, Tramadol (for moderate to severe pain) 50 mg PO every 6 hours PRN for pain 7-10.</p> <p>Review of Resident 56's March, April, and May 2024 MAR (medication administration record, a form to document medication administration) revealed that staff administered the following PRN pain medications:</p> <p>Acetaminophen 650 mg PO every 6 hours PRN for arthritic pain</p> <p>March 5, 2024, at 8:53 PM for a pain level of 0.</p> <p>May 12, 2024, at 11:06 AM for a pain level of 5.</p> <p>May 13, 2024, at 4:13 AM for a pain level of 5.</p> <p>Tramadol 50 mg PO every 6 hours PRN for pain 7-10</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>March 5, 2024, at 2:45 PM, for a pain level of 6.</p> <p>March 6, 2024, at 7:39 PM, for a pain level of 0.</p> <p>March 9, 2024, at 9:51 PM, for a pain level of 5.</p> <p>March 11, 2024, at 8:06 PM, for a pain level of 3.</p> <p>March 13, 2024, at 2:01 PM, for a pain level of 6.</p> <p>March 16, 2024, at 7:59 PM, for a pain level of 0.</p> <p>March 19, 2024, at 7:58 PM, for a pain level of 6.</p> <p>March 21, 2024, at 7:53 PM, for a pain level of 5.</p> <p>March 22, 2024, at 7:48 PM, for a pain level of 4.</p> <p>March 25, 2024, at 6:50 PM, for a pain level of 6.</p> <p>March 29, 2024, at 9:11 PM, for a pain level of 4.</p> <p>April 5, 2024, at 9:17 PM, for a pain level of 5.</p> <p>April 7, 2024, at 7:49 PM, for a pain level of 0.</p> <p>April 9, 2024, at 8:21 PM, for a pain level of 0.</p> <p>April 11, 2024, at 7:43 PM, for a pain level of 0.</p> <p>April 13, 2024, at 4:04 PM, for a pain level of 3.</p> <p>April 13, 2024, at 10:11 PM, for a pain level of 0.</p> <p>April 18, 2024, at 4:03 PM, for a pain level of 0.</p> <p>April 18, 24, at 10:44 PM, for a pain level of 4.</p> <p>April 19, 2024, at 8:06 PM, for a pain level of 5.</p> <p>April 23, 2024, at 4:01 PM, for a pain level of 4.</p> <p>April 26, 2024, at 8:07 PM, for a pain level of 0.</p> <p>April 28, 2024, at 7:09 PM, for a pain level of 3.</p> <p>May 8, 2024, at 1:45 AM for a pain level of 6.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>May 11, 2024, at 8:05 PM, for a pain level of 5.</p> <p>May 12, 2024, at 10:20 PM, for a pain level of 3.</p> <p>May 15, 2024, at 4:00 PM, for a pain level of 0.</p> <p>May 18, 2024, at 8:17 PM, for a pain level of 5.</p> <p>May 21, 2024, at 8:16 PM, for a pain level of 0.</p> <p>Clinical record review for Resident 96 revealed physician orders for the following pain medications:</p> <p>Ordered on October 14, 2022, Acetaminophen 650 mg PO every 6 hours PRN for pain 1-7, not to exceed 3 grams in 24 hours.</p> <p>Ordered on September 11, 2023, Morphine Sulfate (for moderate to severe pain) 20 mg/milliliter (mg/ml) 0.25 ml PO every 2 hours PRN for pain 1-5 or dyspnea (difficulty breathing) and give 0.5 ml PO every 2 hours PRN severe pain 6-10 or dyspnea.</p> <p>There was no documentation that the facility identified which pain medication that staff were to administer for mild, moderate, and/or severe pain parameters or that the facility identified that multiple medications were available for the same pain parameter.</p> <p>Clinical record review for Resident 123 revealed physician orders for the following pain medications:</p> <p>Ordered on May 3, 2024, Acetaminophen extra strength 500 mg 2 tablets via peg tube every 6 hours PRN for breakthrough pain 1-5.</p> <p>Ordered on May 3, 2024, Percocet (for moderated to severe pain) 10-325 mg via peg tube every 4 hours PRN for pain 6-10.</p> <p>Review of Resident 123's May 2024 MAR revealed that staff administered the following PRN pain medications:</p> <p>Percocet 10-325 mg via peg tube every 4 hours PRN for pain 6-10</p> <p>May 6, 2024, at 1:56 PM for a pain level of 0.</p> <p>May 7, 2024, at 5:30 PM for a pain level of 3.</p> <p>May 12, 2024, at 6:16 PM for a pain level of 0.</p> <p>May 13, 2024, at 10:10 AM for a pain level of 5.</p> <p>May 13, 2024, at 2:26 PM for a pain level of 5.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>May 15, 2024, at 10:05 AM for a pain level of 5.</p> <p>May 15, 2024, at 4:00 PM for a pain level of 0.</p> <p>May 15, 2024, at 10:37 PM for a pain level of 3.</p> <p>May 16, 2024, at 6:00 PM for a pain level of 4.</p> <p>May 19, 2024, at 10:34 AM for a pain level of 5.</p> <p>May 19, 2024, at 3:01 PM for a pain level of 5.</p> <p>The surveyor reviewed the above pain information during an interview the Nursing Home Administrator and Director of Nursing on May 22, 2024, at 2:57 PM.</p> <p>483.25(k) Pain Management</p> <p>Previously cited 6/16/23</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>18229</p> <p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to identify triggers related to a resident's diagnosis of Post-Traumatic Stress Disorder, to provide culturally, competent, trauma-informed care, and to eliminate or mitigate re-traumatization for two of four residents reviewed for mood/behavior (Residents 93 and 112).</p> <p>Findings include:</p> <p>Clinical record review revealed the facility admitted Resident 93 on May 19, 2022, and added a diagnosis of Chronic Post Traumatic Stress Disorder (PTSD, a mental and behavioral disorder that develops related to a terrifying event) on October 9, 2022.</p> <p>Review of a psychiatry note dated August 23, 2022, revealed Resident 93 had a history of premorbid PTSD (a vulnerability that can increase the severity of PTSD symptoms associated with previous trauma exposure when someone is exposed to new stressors).</p> <p>Further review of Resident 93's clinical record there was no evidence that the facility identified Resident 93's history of trauma. A review of Resident 93's care plan revealed there were no identified triggers (everyday situations that cause a person to re-experience the traumatic event as if it was reoccurring).</p> <p>Resident 93's clinical record contained no evidence the facility collaborated with the resident, and as appropriate, the resident's family, friends, and any other healthcare professionals (such as psychologists, and mental health professionals) to develop and implement individualized interventions.</p> <p>Clinical record review revealed that the facility admitted Resident 112 on October 27, 2023, and added a diagnosis of PTSD on February 11, 2024.</p> <p>Review of the psychiatry note dated February 5, 2024, revealed Resident 112 had a diagnosis of chronic PTSD. Further review of Resident 112's clinical record revealed there was no evidence that the facility identified Resident 112's history of trauma. A review of Resident 93's care plan revealed there were no identified triggers.</p> <p>Resident 112's clinical record contained no evidence the facility collaborated with the resident, and as appropriate, the resident's family, friends, and any other healthcare professionals (such as psychologists, and mental health professionals) to develop and implement individualized interventions.</p> <p>These findings were reviewed with the Nursing Home Administrator and Director of Nursing on May 22, 2024, at 2:30 PM.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing services</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>18229</p> <p>Based on observation, review of posted daily nurse staffing data, and staff interviews, it was determined that the facility failed to ensure nursing staffing information was posted on three of three resident floors (First, Second, and Third floors).</p> <p>Findings include:</p> <p>Observation of the facility on May 20, 2024, at 11:31 AM and again on May 23, 2024, at 11:27 revealed the facility failed to post the nurse staffing data daily on the First, Second, and Third floors in a prominent place that was readily accessible to residents and visitors at the beginning of every shift.</p> <p>These findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on May 23, 2024, at 11:45 AM.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by two of three residents reviewed (Residents 34 and 87).</p> <p>Findings include:</p> <p>Clinical record review for Resident 34 revealed that the facility admitted her on January 4, 2024, with diagnoses including dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life) with agitation. A review of her admission Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated January 10, 2024, indicated that the facility assessed Resident 34 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 34's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss that would include direct care and activities that are focused on understanding, preventing, relieving, and accommodating a resident's distress or loss of abilities.</p> <p>Clinical record review of Resident 87's diagnosis list revealed that he was diagnosed with dementia on October 1, 2022. A review of his significant change MDS dated [DATE], indicated that the facility assessed him as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 87's care plan revealed that there was no indication that the facility developed and implemented a person-centered care plan to address Resident 87's dementia and cognitive loss that would include direct care and activities that are focused on understanding, preventing, relieving, and accommodating a resident's distress of loss of abilities related to his dementia.</p> <p>These findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on May 22, 2023, at 2:12 PM for Residents 34 and 87.</p> <p>483.40(b)(3) Dementia Treatment and Services</p> <p>Previously cited 06/16/23.</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p> <p>28 Pa Code 211.11(d) Resident care plan</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>18229</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 6).</p> <p>Findings include:</p> <p>Observation of the First Floor Nursing Unit on May 20, 2024, at 12:16 PM revealed Resident 6 was visibly upset and pacing in the hallway. Resident 6 approached the surveyor and asked if she worked for the Office of the Aging. Resident 6 opened a piece of paper with the local ombudsman's name and contact information on it and stated that the staff would not allow him to call her. Resident 6 stated that he is being kept prisoner and locked on the unit. Resident 6 proceeded to discuss how he fell at home and hit his head along with possible carbon monoxide poisoning. The resident then drove himself to the hospital. Resident 6 stated that he may have been confused in the hospital due to hitting his head, the hospital transferred him to the facility, and now the facility will not allow him to leave. Resident 6 asked the surveyor to review the resident rights posted on the wall and stated that the facility is not allowing him to have these rights.</p> <p>Email correspondence with the local ombudsman on May 21, 2024, confirmed she had not received any calls from Resident 6.</p> <p>Observation of the First Floor Nursing Unit on May 22, 2024, at 10:21 AM revealed that Resident 6 again was visibly upset and stated that he had requested to speak to the Nursing Home Administrator for over a month and she has not come to address his concerns.</p> <p>Clinical record review revealed the facility admitted Resident 6 on April 1, 2024.</p> <p>Clinical record review and an interview with Employee 6, social services, on May 23, 2024, at 12:53 PM confirmed that Resident 6 had a BIMS (Brief Interview for Mental Status) of 12, which indicated only mild cognitive impairment.</p> <p>A medical provider note dated April 2, 2024, at 7:52 PM revealed the resident was able to complete the Mini Mental Status (a tool utilized to measure the cognitive status) examination, fairly well, and was oriented x 3 (oriented to person, place, and time). The documentation further noted, The resident is generally alert, oriented, with very minimal periods of confusion.</p> <p>A medical provider note dated April 8, 2024, at 1:29 PM revealed that it was reported by nursing staff that Resident 6 is preoccupied in finding ways to exit the facility and had mentioned about attempting to exit through the windows.</p> <p>Nursing documentation for Resident 6 dated May 7, 2024, at 2:01 PM revealed the resident wanted to speak to the person that ran the facility. The resident was going to contact his lawyer to get him out of the facility because, he isn't even sure why he is here.</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>Social services documentation for Resident 6 dated May 9, 2024, at 11:09 AM revealed that the resident's family had questions about the resident and his need for placement at the skilled nursing facility. However, minimal information was provided because they were not on the profile. The family voiced concern about the resident's emergency contact.</p> <p>Nursing documentation for Resident 6 dated May 16, 2024, at 2:16 PM revealed that the resident was very upset and asked staff to call the police because the resident is being held against his will. The staff informed the resident that the police could not be contacted for this matter. The documentation further noted the resident stated that, he would do something serious enough if he had to for the police to be called. The resident was sitting next to the unit door most of the shift and upset that management had not been to see him; however, the Nursing Home Administrator (NHA) had been to see the resident this week according to the documentation.</p> <p>Nursing documentation for Resident 6 dated May 18, 2024, at 3:04 PM revealed the resident told staff that they were going to be involved in a lawsuit and he was being held against his will and will get out of the facility one way or the other.</p> <p>Nursing documentation for Resident 6 dated May 18, 2024, at 8:33 PM revealed the staff assisted the resident with calling his emergency contact. According to the documentation, the emergency contact asked to speak to staff and told them that the resident advised he needs .to get out of here and it is a matter of life and death for him, and I'm starting to come unraveled here.</p> <p>Facility documentation for Resident 6 dated May 21, 2024, at 11:36 AM revealed the emergency contact reported the resident's home is completely uninhabitable and the resident is unable to live alone safely. The emergency contact was unwilling to act as the resident's guardian and the facility will be pursuing guardianship.</p> <p>There was no evidence in the clinical record to indicate that Resident 6 was deemed incapable by a medical professional to make his own decisions. This was confirmed in an interview with Employee 6 during an interview on May 23, 2024, at 12:53 PM.</p> <p>There was no evidence provided to confirm that the facility addressed Resident 6's concerns related to wanting to leave the facility and being held against his will as noted in the nursing documentation or discussed alternative options with the resident (i.e., an assisted living facility). There was no evidence to confirm the facility requested a home assessment to confirm the allegations from the emergency contact that the resident's home was uninhabitable or a danger to the resident's health and safety.</p> <p>The facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>The above findings for Resident 6 were reviewed in a meeting with the NHA and Director of Nursing on May 22, 2024, at 2:00 PM.</p> <p>28 Pa. Code 201.29 (a) Resident rights</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29512</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to properly account for, secure, dispose of, or return physician ordered medications for two or 25 residents reviewed (Residents 125 and 126).</p> <p>Findings include:</p> <p>Closed clinical record review for Resident 125 revealed physician orders dated [DATE], for the following:</p> <p>Lorazepam (schedule 4, controlled medication) Tablet 0.5 milligram (mg) one tablet by mouth (PO) every 4 hours as needed (PRN) for restlessness or Anxiety.</p> <p>Morphine Sulfate (narcotic, controlled medication) 20 mg/ml (milligrams/milliliter) give 0.25 ml PO every 2 hours PRN for pain or Dyspnea (difficulty breathing).</p> <p>Hyoscyamine Sulfate 0.125 mg PO every 4 hours PRN for tracheal (throat) secretions.</p> <p>Review of Resident 125's clinical documentation dated [DATE], revealed that he expired at 3:50 AM.</p> <p>There was documentation that the facility counted Resident 125's Lorazepam and Morphine medications. There was no documentation of the disposition or security of the resident's controlled medications. There was also no documentation accounting for Resident 125's Hyoscyamine after Resident 125 expired.</p> <p>This surveyor reviewed the above information during an interview with the Director of Nursing on [DATE], at 11:00 AM.</p> <p>Closed clinical record review for Resident 126 revealed that she was admitted to the hospital on [DATE], and expired while in the hospital on [DATE].</p> <p>Review of Resident 126's closed clinical record revealed physician orders dated [DATE], for the following:</p> <p>Dexamethasone (used to treat inflammation) 2 milligrams (mg)</p> <p>Furosemide (a fluid pill) 40 mg</p> <p>Gabapentin (used to treat nerve pain or seizures) 600 mg</p> <p>Novolog (insulin used to treat high blood sugars)100units/ml</p> <p>Cyclobenzaprine HCl (a muscle relaxant) 5 mg</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dicyclomine HCl (used to treat irritable bowel syndrome) 20 mg</p> <p>Linzess (used to treat irritable bowel syndrome ad constipation)290 mcg</p> <p>Methocarbamol (used to treat muscle pain and stiffness)500 mg</p> <p>Apixaban (a blood thinner) 5 mg</p> <p>Breo Ellipta Inhaler (used to treat asthma)</p> <p>Cyanocobalamin (a supplement) 1000 mcg</p> <p>Empagliflozin oral (used to lower blood sugars) 25 mg</p> <p>Ergocalciferol (vitamin D that helps the body use more calcium) 1.25 mg</p> <p>Fluoxetine HCl (used to treat depression) 40 mg</p> <p>Insulin glargine (used to treat diabetes) 100 u/ml</p> <p>Levothyroxine (used to treat hypothyroidism) 75 mcg</p> <p>Ropinirole HCl (used to treat restless leg syndrome) 1 mg</p> <p>Seroquel (used to treat certain mental and mood disorders such as bipolar and schizophrenia) 25 mg</p> <p>There was no documentation in Resident 126's clinical record to indicate the disposition of the above medications upon her discharge from the facility.</p> <p>This surveyor reviewed the above information during an interview with the Director of Nursing on [DATE], at 11:40 AM.</p> <p>28 Pa. Code 211.9 (k) Pharmacy services</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>

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NAME OF PROVIDER OR SUPPLIER Williamsport North Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Leader Drive Williamsport, PA 17701	
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 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>36798</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that pharmacy recommendations were responded to for one of five residents reviewed (Resident 87).</p> <p>Findings include:</p> <p>Review of Resident 87's clinical record revealed that the pharmacist completed monthly medication reviews and noted that a recommendation was made on the following dates: October 10, 2023, November 13, 2023, January 9, 2024, and February 8, 2024.</p> <p>Review of the recommendation provided on October 10, 2023, November 13, 2023, January 9, 2024, and February 8, 2024, revealed a request for nursing to correct the diagnosis for Seroquel (a medication used to treat certain mental/mood disorders) on the medication administration record to bipolar disorder (a disorder associated with mood swings ranging from depressive lows to manic highs). Review of Resident 87's clinical record revealed that the diagnosis associated with his Seroquel is behaviors.</p> <p>Interview with the Director of Nursing on May 23, 2024, at 1:30 PM confirmed the above noted findings related to Resident 87's pharmacy recommendations.</p> <p>There was no evidence in Resident 87's clinical record that the facility addressed the above noted medication regimen reviews related to the diagnosis for his Seroquel.</p> <p>28 Pa. Code 211.9 (d)(k) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>29512</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medications for one of five residents reviewed (Resident 41).</p> <p>Findings include:</p> <p>Clinical record review for Resident 41 revealed the following physician orders:</p> <p>Ordered on February 4, 2024, and discontinued on February 11, 2024, for Ativan 0.5 milligram (mg) by mouth PO every 8 hours as needed for increased anxiety.</p> <p>Ordered on February 11, 2024, Ativan Oral Tablet 0.5 mg PO every 8 hours as needed for increased anxiety discontinue after 14 days nonuse.</p> <p>Review of Resident 41's pharmacy recommendation dated February 8, 2024, revealed the pharmacist identified the concerns with the PRN Ativan and indicated for the physician to evaluate if the medication could be discontinued or if a 14 day stop date could be added. The physician's assistant responded on February 11, 2024, agreed with the pharmacist's recommendation, and indicated to discontinue Ativan after 14 days non-use (to be discontinued on February 25, 2024).</p> <p>Review of Resident 41's February, March, April, and May 2024 MAR (medication administration record, a form to document medication administration) revealed the following:</p> <p>Resident 41's PRN Ativan order continued throughout March, April, and May 2024, with staff continued administration noted. Staff administered it 17 times.</p> <p>Staff did not attempt non-medicinal interventions 19 times prior to administering Resident 41's PRN Ativan on or after February 4, 2024.</p> <p>There was 14 days of non-use noted between March 14, 2024, to April 3, 2024, and again on April 13, 2024, to April 27, 2024, if staff were to utilize/implement/identify the 14 days of non-use as noted on Ativan PRN order dated February 11, 2024.</p> <p>The surveyor reviewed the above for Resident 8 during an interview with the Nursing Home Administrator on May 22, 2024, at 1:35 PM.</p> <p>483.45(c)(3)(e)(1)-(5) Free From Unnec Psychotropic Meds/prn Use</p> <p>Previously cited 6/16/23</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy services</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 211.10(a) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36798</p> <p>Based on observation and staff interview, it was determined the facility failed to store food in a safe and sanitary manner in the facility's main kitchen.</p> <p>Findings include:</p> <p>An observation of the facility's main kitchen on May 20, 2024, at 8:00 AM revealed the following:</p> <p>The floor in the dry storage room was dirty with black marks and sticky. There were pieces of cardboard, plastic spoons and forks, and a coffee mate packet noted on the floor. On two food storage units there were black dirt particles on the top shelf of each. Employee 4, Dietary cook, indicated that the black particles were from the air-conditioning unit when they turn it on. The unit was not on at the time of the observation.</p> <p>The refrigerator in the main kitchen, located to the left of the door to the dry storage area (as you are looking at it), had a bag of lettuce, waffles in plastic packaging, and sausage patties wrapped in foil with no date to indicate when they were placed in the refrigerator or an expiration date.</p> <p>The bottom shelf of the freezer located next to the coffee pot had spillage noted on it with cardboard stuck to it.</p> <p>The refrigerator beside the handwashing sink had two bags of cabbage with a use by date of May 11, 2024.</p> <p>The second refrigerator located beside the handwashing sink had a sandwich and a salad with no date on it. Employee 4 indicated that they were not prepared that morning and he was unsure when they were from.</p> <p>Review of the temperature logs for the dishwasher revealed that temperatures were logged for lunch time on the date of observation, and it was only 8:15 AM.</p> <p>Review of the refrigerator temperatures for all three refrigerators (beverage, line, and salad) had no temperatures logged for evening shift on the dates from May 14-17, 2024.</p> <p>Review of the temperature logs for all three freezers (ice cream, cooks, and vegetable) had no temperatures logged for evening shift from May 14-17, 2024.</p> <p>All concerns were reviewed at the time of the observations with Employee 4.</p> <p>The Nursing Home Administrator was made aware of the above noted concerns on May 21, 2024, at 2:42 PM.</p> <p>42 CFR 483.60(i)(2) Store/Prepare/Distribute-Sanitary</p> <p>(continued on next page)</p>

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Previously cited 7/25/23 28 Pa. Code 201.14 (a) Responsibility of licensee

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>44738</p> <p>Based on observation and staff interview, it was determined that the facility failed to ensure a safe and clean environment in the facility laundry area.</p> <p>Findings include:</p> <p>Observation of the facility's main laundry area with Employee 1, laundry aide, and the Nursing Home Administrator on May 23, 2024, at 9:28 AM revealed an extensive build-up of wet lint, debris including three discarded medical gloves, a plunger head, and a dirty blanket behind the area of the main washing machines.</p> <p>Excessive lint buildup not only affects dryer performance but can also be a fire hazard. Regular maintenance and cleaning are essential to keep the dryer functioning properly and safely.</p> <p>28 Pa. Code 201.18 (b)(1)(3) Management</p>		