

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Capitol Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  4000 Linglestown Road Harrisburg, PA 17112	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33305</p> <p>Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for four of 25 residents reviewed (Residents 11, 17, 91, and 101).</p> <p>Findings include:</p> <p>Review of Resident 11's clinical record revealed diagnoses that included dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability) and age-related osteoporosis (occurs when bones become weaker and more fragile due to the aging process).</p> <p>Further review of Resident 11's clinical record revealed that Resident 11 had a fall on February 18, 2024, without injury.</p> <p>A review of Resident 11's Quarterly MDS (minimum data set-periodic assessment) dated April 16, 2024, was marked for a fall with major injury.</p> <p>Further review of the clinical record failed to reveal any documentation of a fall with major injury.</p> <p>The clinical record for Resident 11 revealed that on April 4, 2024, the Resident complained of pain in her left upper arm and shoulder. The physician was notified and assessed the Resident, noting that her left arm hung lower than the right arm. X-rays were ordered and revealed that the bones with osteopenia (body doesn't make new bone as quickly as it reabsorbs the old bone), there was an age-indeterminate comminuted left humeral fracture (a break in the upper arm bone that occurs in at least two places), and a distal fragment is medially displaced over the axillary region.</p> <p>During an interview with Employee 6 (RNAC-Registered Nurse Assessment Coordinator) she confirmed that Resident 11's April 16, 2024, MDS was marked in error. Employee 6 said that the RNAC marked that MDS as a fall with major injury due to the report of the x-ray assuming the fracture occurred with the February 18, 2024, fall. The fall investigation report for February 18, 2024, failed to reveal any injury or complaints of pain. Employee 6 informed the surveyor that the April 16, 2024, MDS will be corrected and resubmitted.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Director of Nursing (DON) on October 8, 2024, the DON confirmed that there was no fall with major injury and that the MDS for Resident 11 was marked in error.</p> <p>Review of Resident 17's clinical record revealed diagnoses that included end stage renal disease (kidneys no longer function) and dependence on renal dialysis (treatment needed to clean waste from the body due to kidney failure).</p> <p>Review of Resident 17's physician orders revealed an order for dialysis treatments three times a week.</p> <p>During an interview with Resident 17 on October 6, 2024 at 12:40 PM, it was revealed that Resident 17 had been admitted to the facility about one month ago. Resident 17 also revealed he had started dialysis treatments several months ago due to kidney failure.</p> <p>Review of Resident 17's admission MDS assessment dated [DATE], revealed Resident 17 was coded as not receiving dialysis on admission.</p> <p>Further review of Resident 17's clinical record revealed a hospital discharge summary dated September 7, 2024.</p> <p>Review of the hospital discharge summary revealed Resident 17 had been receiving dialysis services at the time of admission.</p> <p>During an interview on October 7, 2024, at 1:29 PM, Employee 6 revealed Resident 17's admission MDS was coded incorrectly.</p> <p>During an interview on October 8, 2024 at 1:49 PM, with the DON and Nursing Home Administrator (NHA), the DON stated that it was the expectation of the facility that MDS assessments be accurate.</p> <p>Review of Resident 91's clinical record revealed diagnoses that included stroke (damage to the brain from interruption of its blood supply) and Stage 4 pressure ulcer (wound of the skin caused by pressure over a bony prominence that extends to the muscle, tendons, ligaments, and bone).</p> <p>Further review of Resident 91's clinical record revealed that they acquired their stage 4 pressure ulcer at the facility in January 2023.</p> <p>Review of Resident 91's Quarterly MDS with the assessment reference date of May 4, 2024, revealed in Section M. Skin Conditions that their pressure ulcer was coded as being present upon admission to the facility.</p> <p>Review of Resident 91's Quarterly MDS with the assessment reference date of August 4, 2024, revealed in Section M. Skin Conditions that their pressure ulcer was coded as being present upon admission to the facility.</p> <p>Email communication received from Employee 7 (Regional Director of Clinical Services) on October 9, 2024, indicated that Resident 91's MDS's were coded inaccurately.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Email communication received from the DON on October 9, 2024, at 1:01 PM, indicated that she would expect a resident's MDS assessments to be coded accurately.</p> <p>Review of Resident 101's clinical record revealed diagnoses that included dementia and unspecified psychosis (severe mental condition in which thought and emotions are so affected that contact can be lost with reality).</p> <p>Review of Resident 101's Quarterly MDS with the assessment reference date of June 7, 2024, indicated in Section N. Medications that the Resident had received an antipsychotic medication on a routine basis and that their physician had not documented that a gradual dosage reduction was clinically contraindicated.</p> <p>Review of Resident 101's clinical record revealed a psychiatric consult visit note dated April 19, 2024, that indicated that a gradual dose reduction of their antipsychotic medication was clinically contraindicated.</p> <p>Review of Resident 101's Quarterly MDS with the assessment reference date of September 19, 2024, indicated in Section N. Medications that the Resident had received an antipsychotic medication on a routine basis and that their physician had not documented that a gradual dosage reduction was clinically contraindicated.</p> <p>Review of Resident 101's clinical record revealed a psychiatric consult visit note September 16, 2024, that indicated that a gradual dose reduction of their antipsychotic medication was clinically contraindicated.</p> <p>During a staff interview with Employee 3 (Registered Nurse Assessment Coordinator) on October 9, 2024, at 8:59 AM, she confirmed that the gradual dose reduction clinically contraindicated dates should have been included in Resident 101's MDS assessments and that modifications would be completed.</p> <p>During a staff interview with the Nursing Home Administrator and DON on October 9, 2024, at 12:12 PM, the DON confirmed that she would expect a resident's MDS assessments to be completed accurately.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing Services</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>40010</p> <p>Based on facility policy review, observation, clinical record review, and resident representative and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for four of 25 residents reviewed (Residents 65, 102, 106, and 113), and failed to give the opportunity to participate in the development, review, and revision of his/her care plan for four of 25 residents reviewed (Residents 41, 73, 91, and 101).</p> <p>Findings include:</p> <p>Review of facility policy, titled Care Plans, Comprehensive Person-Centered, with a last revised date of March 2022, and last review date of June 17, 2024, read, in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change; 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident; 4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process; e. participate in establishing the expected goals and outcomes of care; f. participate in determining the type, amount, frequency and duration of care; and 5. The resident is informed of his or her right to participate in his or her treatment, and provided advance notice of care planning conferences.</p> <p>Review of Resident 65's clinical record revealed diagnoses that included acute embolism (a life-threatening condition that occurs when a blood clot blocks a pulmonary artery) and thrombosis (when blood clots block veins or arteries).</p> <p>Review of Resident 65's physician orders on October 7, 2024, revealed an order for Apixaban (anticoagulant medication) 2.5 mg twice daily, with a start date of September 1, 2024.</p> <p>Review of Resident 65's care plan on October 7, 2024, failed to reveal a care plan with any information regarding Resident 65's anticoagulation therapy.</p> <p>Interview with the Director of Nursing (DON) on October 9, 2024, at 12:33 PM, revealed that Resident 65's care plan should include care information regarding her use of anticoagulant medication.</p> <p>Review of Resident 102's clinical record revealed diagnoses that included protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function) and acute respiratory failure (a condition where you don't have enough oxygen in the tissues in your body).</p> <p>Review of Resident 102's POLST (Pennsylvania Orders for Life Sustaining Treatment) completed and signed on December 6, 2023, revealed that Resident 102's Representative indicated that Resident 102 should have DNR (do not resuscitate) status.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 41's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and cerebral infarction (a stroke-damage to the brain from interruption of its blood supply).</p> <p>Review of Resident 41's clinical record revealed that the facility had completed quarterly assessments on May 13, 2024, and August 13, 2024.</p> <p>Further review of Resident 41's clinical record revealed that their last documented care plan meeting occurred on February 29, 2024.</p> <p>Review of Resident 73's clinical record revealed diagnoses that included dementia and thyroid cancer.</p> <p>Review of Resident 73's clinical record revealed that the facility had completed a quarterly assessment on August 24, 2024.</p> <p>Further review of Resident 73's clinical record revealed that their last documented care plan meeting occurred on June 21, 2024.</p> <p>Review of Resident 91's clinical record revealed diagnoses that included stroke and pressure ulcer (wound of the skin caused by pressure over a bony prominence that extends to the subcutaneous tissue).</p> <p>During an interview with Resident 91's Representative on October 6, 2024, at 1:21 PM, they indicated that they had not participated in a care plan meeting in six months and that, when they asked about the care plan meetings, they were told the facility was down a Social Worker.</p> <p>Review of Resident 91's clinical record revealed that the facility had completed quarterly assessments on May 4, 2024, and August 24, 2024.</p> <p>Further review of Resident 91's clinical record revealed that their last documented care plan meeting occurred on February 15, 2024.</p> <p>Review of Resident 101's clinical record revealed diagnoses that included dementia and unspecified psychosis (severe mental condition in which thought and emotions are so affected that contact can be lost with reality).</p> <p>Review of Resident 101's clinical record revealed that the facility had completed quarterly assessments on June 7, 2024; September 7 and 19, 2024.</p> <p>Further review of Resident 101's clinical record revealed that their last documented care plan meeting occurred on March 22, 2024.</p> <p>During a staff interview with the DON on October 8, 2024, at 10:11 AM, she indicated that the facility Social Worker was off on a medical leave and that, although they had someone to cover the Social Worker's leave, not all resident care plan meetings occurred.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a final staff interview with the NHA and DON on October 8, 2024, at 1:51 PM, the DON confirmed that the care plan meetings should have been held, and that Residents 41, 73, 91, and 101 or their Representatives should have been invited to participate.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(2)(3)(5) Nursing services</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>33305</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice when administering medications for five of 22 residents reviewed on the East Wing (Residents 11, 21, 43, and 55), and that physician orders are discontinued for one of 25 residents reviewed (Resident 99).</p> <p>Findings Include:</p> <p>Review of Resident 11's clinical record revealed diagnoses that included hypothyroidism (thyroid doesn't produce enough thyroid hormone) and age-related osteoporosis (occurs when bones become weaker and more fragile due to the aging process).</p> <p>A review of Resident 11's clinical record revealed she was ordered Levothyroxine 75 mcg (micrograms) daily at 6:00 AM.</p> <p>A review of Resident 11's medication administration record failed to reveal that the medication was initialed by Employee 10 as administered on October 6, 2024, at 6:00 AM.</p> <p>Review of Resident 21's clinical record revealed diagnoses that included hypothyroidism (thyroid doesn't produce enough thyroid hormone) and insomnia (difficulty sleeping).</p> <p>A review of Resident 21's clinical record revealed she is ordered Levothyroxine for hypothyroidism 88 mcg every other day at 6:00 AM that was due on October 6, 2024.</p> <p>A review of Resident 21's medication administration record failed to reveal that the medication was initialed by Employee 10 as administered on October 6, 2024, at 6:00 AM.</p> <p>Review of Resident 43's clinical record revealed diagnoses that included hypothyroidism (thyroid doesn't produce enough thyroid hormone) and insomnia (difficulty sleeping).</p> <p>A review of Resident 43's clinical record revealed she is ordered Levothyroxine for hypothyroidism 50 mcg daily at 6:00 AM.</p> <p>A review of Resident 43's medication administration record administration section failed to reveal that the medication was initialed by Employee 10 as administered on October 6, 2024, at 6:00 AM.</p> <p>Review of Resident 55's clinical record revealed diagnoses that included hypothyroidism (thyroid doesn't produce enough thyroid hormone) and hypertension (elevated blood pressure).</p> <p>A review of Resident 55's clinical record revealed she is ordered Levothyroxine for hypothyroidism 62.5 mcg daily at 6:00 AM.</p> <p>A review of Resident 55's medication administration record administration section failed to reveal that the medication was initialed by Employee 10 as administered on October 6, 2024, at 6:00 AM.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Director of Nursing (DON) on October 7, 2024, at approximately 10:00 AM, she informed this surveyor that all medications should be signed off by staff immediately after administering the medication. The DON also stated that she interviewed Employee 10, who said she did administer the medication and the levothyroxine doses were not present in the Resident's medication compartments. The DON notified the physician regarding the situation.</p> <p>A review of Resident 99's clinical record revealed diagnoses that included dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability) and depression (major loss of interest in pleasurable activities, characterized by change in sleep patterns, appetite and or daily routine).</p> <p>A review of Resident 99's physician orders dated October 2024 revealed an order to provide the Resident with an extra 240 cc (equals 8 ounces) of fluids every shift x (times) 5 days effective June 10, 2024, and on October 7, 2024, the order was still active.</p> <p>During an interview with the DON on October 7, 2024, at approximately 10:00 AM, she informed the surveyor that the physician never added a stop date to the order, so the order remained in effect.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</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>33305</p> <p>Based on facility policy review, clinical record review, facility document review, and resident and staff interviews, it was determined that the facility failed to administer the correct dosage of medication for one of 25 residents reviewed (Resident 41); and failed to ensure that physician's orders were implemented for three of 22 residents on the East Wing (Residents 69, 87, 89).</p> <p>Findings include:</p> <p>A review of the facility policy, titled Administering Medications, last revised April 2019, revealed that the individual administering the medications records in the resident's medical record; the date and the time the medication was administered; the dosage; the signature and title of the person administering the medication. The individual administering medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right route of administration before giving the medication.</p> <p>Review of Resident 41's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and cerebral infarction (a stroke-damage to the brain from interruption of its blood supply).</p> <p>Review of Resident 41's current physician orders revealed an order for oxycodone (a controlled opioid pain medication) oral tablet 5 mg give 0.5 tablet by mouth every six hours as needed for severe pain, dated February 19, 2024.</p> <p>Review of Resident 41's progress notes revealed a note dated May 6, 2024, that indicated a nurse had identified that Resident 41's medication card for their ordered oxycodone contained tablets that were 5 mg (milligrams) and that it was noted on the controlled substance log that only one of the six documented medication administrations had indicated that half a tablet was wasted; therefore, Resident 41 received the wrong medication dose on five occasions (March 5, 9, 14, and 21, 2024; and May 6, 2024). The note also indicated that Resident 41 had no negative outcomes and that their Representative and physician was made aware of the error.</p> <p>Review of facility provided medication error report revealed that Employees 11, 12, and 13 confirmed that they gave the wrong dose of oxycodone to Resident 41.</p> <p>During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on October 9, 2024, at 12:11 PM, the DON indicated education was provided to all licensed nurses regarding the 10 rights to medication administration, and she confirmed that she would expect nurses to administer the correct doses of medication as ordered.</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>During the survey screening process on October 6, 2024, at approximately 11:45 AM, Resident 87 ambulated to the hall to inform this surveyor that she was not administered her 6:00 AM medications by the night shift nurse on that morning. During the conversation, Employee 9 (Licensed Practical Nurse) was present and stated that Resident 87 also informed her that the medications were not administered when she started her medication pass on day shift, and that she notified the Supervisor, who was going to notify the physician. Employee 9 also stated that she requested an order for the analgesic so that she wouldn't have to wait several hours until the next dose was due. Resident 87 said that she needs her Tylenol because she has pain in the morning when she first gets out of bed.</p> <p>A review of Resident 87's BIMS (brief interview of mental status) reveals a score of 15, indicating she is cognitively intact.</p> <p>Review of the clinical record revealed the medication administration record (MAR) was not signed off for Buspar (anxiolytic- to decrease anxiety/depression) and Tylenol (analgesic for pain).</p> <p>During interview with Employee 9 on October 6, 2024, the employee stated that other residents stated they did not receive their early morning medications and that the Supervisor was made aware of the reports.</p> <p>The DON interviewed the three residents that were capable of interviews, based on a BIMS score. Resident 87 informed the DON that she had not received her 6:00 AM medications that included the buspar and Tylenol; Resident 69 informed the DON that she didn't receive her 6:00 AM Lasix (diuretic to decrease edema) for a diagnoses of congestive heart failure (excessive body/lung fluid caused by a weakened heart); and Resident 89 informed the DON that she didn't receive her 6:00 AM medications that included Tylenol for pain and phenobarbital for seizures (uncontrolled jerking, loss of consciousness, blank stares and other symptoms caused by abnormal electrical activity in the brain).</p> <p>A review of the clinical records for Resident 69 and Resident 89 revealed their 6:00 AM medications were not signed off to indicate administration. The phenobarbital narcotic count revealed the 6:00 AM dose was present and not administered as ordered by Employee 10.</p> <p>The DON was made aware of the complaints of medication omissions on October 6, 2024, by the night shift supervisor, and began an investigation that included interviewing staff and residents and contacting the individual assigned to the medication pass from 5:00 AM until 6:00 AM on October 6, 2024. The facility interview with Employee 10 revealed that Employee 10 stated she gave the medications but didn't sign them off because she thought she could do that at home remotely. The Tylenol is a stock medication so administration could not be confirmed, four doses of levothyroxine (to treat hypothyroidism when thyroid doesn't produce enough thyroid hormone) could not be confirmed as administered, the levothyroxine doses were not present, indicating the medication was removed to administer but the Medication Administration Record (MAR) was not signed off as administered.</p> <p>During an interview with the DON on October 7, 2024, at approximately 11:00 AM, the DON confirmed that medications should be administered as prescribed and initialed by the individual after administration. The DON also informed this surveyor that staff are never given remote access.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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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>46253</p> <p>Based on facility policy review, clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, to promote healing of a pressure ulcer for one of four residents reviewed for pressure ulcers (Resident 91).</p> <p>Findings include:</p> <p>Review of facility policy, titled Dressings, Dry/Clean, with a last revised date of September 2013, and a last review date of June 17, 2024, revealed, in part, Steps in Procedure 7. Pull glove over dressing and discard into plastic or biohazard bag. 8. Wash and dry your hands thoroughly. 9. Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface. 17. Apply the ordered dressing. Also, section titled Documentation indicated The following information should be recorded in the resident's medical record, treatment sheet or designated wound form: 1. The date and time the dressing was changed; 3. The name and title (or initials) of the individual changing the dressing.</p> <p>Review of Resident 91's clinical record revealed diagnoses that included stroke (damage to the brain from interruption of its blood supply) and Stage IV pressure ulcer (wound of the skin caused by pressure over a bony prominence that extends to the muscle, tendons, ligaments, and bone).</p> <p>Review of Resident 91's physician order revealed an order for Stage IV Left Buttock: Cleanse wound with Vashe, apply triple mix ointment (1% hydrocortisone, zinc oxide, antifungal ointment mixed in equal parts) to wound, apply Aquacel Ag rope to wound opening, (pack loosely), covered with mepilex sacral border, change twice a day and prn [as needed] soilage every day and evening shift for left buttock wound, dated September 26, 2024.</p> <p>During an observation of Resident 91's wound care on October 9, 2024, at 7:59 AM, with Employee 4 and Employee 5, Employee 4 was observed to cleanse the wound, removed the gloves, and then directly touched the rope wound packing material with their ungloved hands while cutting it to fit the wound. Employee 4 then used hand sanitizer to cleanse hands, applied gloves, and continued with the dressing application. Employee 4 was noted to cover the wound with a square foam bordered dressing approximately 4 inches by 4 inches.</p> <p>During an interview with Employee 4 on October 9, 2024, at approximately 8:15 AM, with Employee 4, confirmed that they did touch the wound packing material with their bare hands while cutting it. Employee 4 indicated that their hands were clean because she used her hand sanitizer. When told that they were not observed using the hand sanitizer, Employee 4 said I thought I did, but maybe I didn't.</p> <p>Review of Resident 91's September Treatment Administration Record revealed that there was no documentation that Resident 91 received the ordered wound treatment on September 8, 2024, or on September 29, 2024, evening shift.</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>During an inspection of wound care dressing supplies on October 9, 2024, at approximately 11:30 AM, it was noted that Employee 4 failed to utilize the ordered Aquacel AG (silver infused) rope as ordered. In addition, a sacral shaped mepiplex border dressing was not applied to the wound.</p> <p>During a staff interview with the Nursing Home Administrator and Director of Nursing (DON) on October 9, 2024, at 12:11 PM, the DON confirmed that she would expect physician orders to be followed, treatments to be provided as ordered, and that Employee 4 should not have touched the wound packing with an ungloved hand.</p> <p>During a follow-up staff interview with the DON on October 9, 2024, at 1:00 PM, she indicated that she had no additional information to provide as to why the dressing changes were not completed as ordered on September 8 and 29, 2024.</p> <p>During a staff interview with Employee 4 and Employee 5 on October 9, 2024, at 1:23 PM, they both confirmed that Aquacel rope was used, but that it did not contain silver as was ordered by Resident 91's physician.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(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>Provide enough food/fluids to maintain a resident's health.</p> <p>48484</p> <p>Based on facility policy review, clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to monitor hydration status precisely and effectively for one of 25 residents reviewed (Resident 14).</p> <p>Findings include:</p> <p>Review of facility policy, titled Encouraging and Restricting Fluids, last revised October 2010, read, in part, The purpose of this procedure is to provide the resident with amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids. Review the resident's care plan and/or your daily assignment sheet to assess for any special needs of the resident. Follow specific instructions concerning fluid intake or restrictions. Be accurate when recording fluid intake.</p> <p>Review of Resident 14's clinical record revealed diagnoses that included congestive heart failure (CHF- a long-term condition that happens when your heart can't pump blood well enough to meet your body's needs), chronic kidney disease (a condition characterized by a gradual loss of kidney function), and hypertension (high blood pressure).</p> <p>Review of Resident 14's physician orders revealed an order: 2000 mL fluid restriction Nursing: 560 ml/24hr, (240 ml on 7-3, 220 ml on 3-11, 100 ml on 11-7) Dietary: 1440 ml/24hr (480 ml @Breakfast, 480 ml @Lunch, 480 ml @Dinner) every shift for CHF protocol, communicate shift to shift on mLs consumed, with a start date of September 30, 2024.</p> <p>Review of Resident 14's care plan revealed an intervention for fluid restriction as ordered, with a start date of July 5, 2021.</p> <p>Observation in Resident 14's room on October 6, 2024, at 10:16 AM, revealed he had 120 ml cranberry juice, 240 ml of milk, and a 240 ml cup of coffee, which is more than what should be provided from dietary at breakfast per physician order.</p> <p>Observation in Resident 14's room on October 8, 2024, at 9:48 AM, revealed he two 480 mL Styrofoam cups of water form nursing, one was full and one was half full, which was more than the 240 mL allowed that shift.</p> <p>During an interview with Resident 14 in his room on October 8, 2024, at 9:48 AM, he revealed he did not believe he was on a fluid restriction.</p> <p>Interview with Employee 1 (Licensed Practical Nurse) on October 8, 2024, at 9:50 AM, the surveyor questioned how Resident 14's fluid restriction is managed. Employee 1 revealed the nurse aides pass him allowed fluids and let her know how much he consumed. She further revealed the reason he was provided excess fluids is because the nurse aide students were passing fluids that morning, and they would not be aware of his fluid restriction.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 14's meal tray tickets on October 7, 2024, revealed at breakfast he was provided 3/4 cup of juice, one cup of milk, and one cup of coffee, which was over the allowed amount of fluids from dietary.</p> <p>Further review of Resident 14's meal tray tickets on October 7, 2024, revealed at dinner he was provided 1/2 cup of juice, one cup of coffee, and 180 ml of soup.</p> <p>Interview with Employee 2 (Regional Director of Dining) on October 8, 2024, at 12:57 PM, revealed he reviewed Resident 14's meal tickets and identified a concern with his fluid restriction being followed. He further revealed Resident 14 is also being provided soup and ice cream at certain meals, which would count as fluids, and that they did not serve his soup at lunch that day as that would have put him over his allowed fluids from dietary.</p> <p>Review of Resident 14's MAR (Medication Administration Record - documentation for treatments/medication administered or monitored) revealed he was documented as consuming excess fluids allowed from nursing on five shifts in October 2024.</p> <p>During an interview with the Nursing Home Administrator and Director of Nursing (DON) on October 8, 2024, at 1:35 PM, the surveyor revealed the concern with the overall management of Resident 14's fluid restriction, and that nursing has recorded mls consumed in excess of his fluid restriction order on several shifts.</p> <p>Follow-up interview with the DON on October 9, 2024, at 11:01 AM, revealed she spoke with the nurses who documented excess fluids on the aforementioned shifts, and they said that those were documentation errors. She further revealed they have identified issues with fluid restrictions and that they have provided a list of residents on fluid restrictions to the doctor for review. No further information as provided.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>48484</p> <p>Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to maintain complete and accurate records related to dialysis communication for one of two residents reviewed for dialysis (Resident 77).</p> <p>Findings include:</p> <p>Review of facility policy, titled End stage renal disease, Care of a Resident with, last revised September 2010, read, in part, Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Education and training of staff includes, specifically: The nature and clinical management of ESRD; The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis; Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: How information will be exchanged between the facilities. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care.</p> <p>Review of Resident 77's clinical record revealed diagnoses that included ESRD (failure of kidney function to remove toxins from blood), hypertension (elevated/high blood pressure), and dependence on renal dialysis (an artificial process for removing waste products and excess fluids from the body, a process that is needed when the kidneys are not functioning properly).</p> <p>Review of Resident 77's physician orders revealed an order for Dialysis: Monday-Wednesday-Friday. Arrival time is at 1000 am to 1015 am every day shift every Mon, Wed, Fri, with a start date of April 3, 2024.</p> <p>Review of Resident 77's dialysis communication sheets revealed there were missing communication sheets February 7-March 11, 2024; April 8, 2024; May 6 and 29, 2024; July 15 and 26, 2024; August 5, 16, and 26, 2024; and September 20, 23, and 25, 2024.</p> <p>Further review of Resident 77's dialysis communication sheets provided failed to reveal post-dialysis weights recorded on August 12, 2024, and September 6, 2024.</p> <p>Interview with the Director of Nursing (DON) on October 8, 2024, at 1:28 PM, revealed if information such as post-dialysis weights were not recorded on the communication sheets, she would reach out to dialysis for the missing information.</p> <p>Follow-up interview with the DON on October 8, 2024, at 1:28 PM, revealed they are unable to locate the missing communication sheets or missing documentation from the reviewed communication sheets. The surveyor revealed the concern with the missing dialysis communications and information. The DON further revealed the facility has identified issues with dialysis communication and they are working on fixing that process.</p> <p>28 Pa code 211.5(f) Medical records</p> <p>28 Pa Code 211.12(c)(d)(1)(3)(5) Nursing services</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40010</p> <p>Based on observations, policy review, clinical record review, and staff interview, it was determined that the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determine that drug records are in order and that account of all controlled drugs is maintained and periodically reconciled for three of three residents reviewed (Resident 63, 117, and 119).</p> <p>Findings include:</p> <p>Review of facility provided policy, Discarding and Destroying Medications, revised [DATE], revealed, 10. The medication disposition record contains, as a minimum, the following information:</p> <ol style="list-style-type: none"> <li>a. The resident's name.</li> <li>b. The name and strength of the medication.</li> <li>c. The prescription number (if any).</li> <li>d. The name of the dispensing pharmacy.</li> <li>e. Date medication destroyed.</li> <li>f. The quantity destroyed.</li> <li>g. Method of destruction.</li> <li>h. Reason for destruction.</li> <li>i. Signature of witnesses.</li> </ol> <p>11. Completed medication disposition records are kept on file in the facility for at least two (2) years, or as mandated by state law governing the retention and storage of such records.</p> <p>Review of Resident 63's clinical record revealed diagnoses that included muscle weakness and hypertension (high blood pressure).</p> <p>Further review of Resident 63's clinical record revealed Resident 63 was discharged from the facility on [DATE].</p> <p>Review of Resident 63's closed record failed to include a medication disposition record.</p> <p>During an email correspondence with the Director of Nursing (DON) on [DATE] at 1:05 PM, she confirmed that the facility was unable to provide a medication disposition record for Resident 63's medications upon discharge.</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 - Some</p>	<p>Review of Resident 117's clinical record revealed diagnoses that included muscle wasting and atrophy (loss of muscle mass due to weakening and shrinking) and pulmonary embolism without acute cor pulmonale (blockage in the pulmonary artery of the lungs).</p> <p>Further review of Resident 117's clinical record revealed Resident 117 was discharged from the facility on [DATE].</p> <p>Review of Resident 117's closed record failed to reveal a medication disposition record.</p> <p>An email communication on [DATE], at 1:11 PM, with the DON revealed that the facility was unable to provide documentation that a medication reconciliation had been completed.</p> <p>Review of Resident 119's clinical record revealed diagnoses of Chronic obstructive pulmonary disease (COPD - a common lung disease that makes it difficult to breathe) and acute respiratory failure (a condition where you don't have enough oxygen in the tissues in your body).</p> <p>Review of the clinical record revealed that the resident was discharged from the facility on [DATE]</p> <p>Review of Resident 119's previous physician's orders on [DATE], revealed that Resident 119 had a physician's order for morphine sulphate (opioid pain medication) 5 mg every four hours, as needed for pain or shortness of breath. The order was valid from [DATE], until the time of Resident 119's death on [DATE], at 8:02 AM.</p> <p>Review of Resident 119's clinical record failed to reveal a medication disposition record, including morphine sulphate.</p> <p>Interview with the Director of Nursing on [DATE], at 11:30 AM, revealed that the medication disposition sheets for the morphine sulfate were not in Resident 119's chart, where they are supposed to be, and could not be located. She also revealed that she did not know the disposition of the remaining morphine sulfate.</p> <p>28 Pa. Code 211.9(j)Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>