| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395373 | A. Building<br>B. Wing | 02/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Greenwood Center for Rehabilitation and Nursing | 276 Green Ave Extended<br>Lewistown, PA 17044 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725<br><br>Based on clinical record review and staff interview it was determined that the facility failed to provide the highest practicable care regarding physician ordered diagnostic testing for one of three residents reviewed (Resident CR1) and physician ordered medications that resulted in hospitalization for one of three residents reviewed resulting in harm (renal failure and digoxin toxicity) (Resident 1).<br><br>Findings include:<br><br>Closed clinical record review for Resident CR1 revealed physician documentation by Employee 2 (physician) dated January 20, 2025, at 12:35 PM that indicated Resident CR1 presented with a cough. The assessment indicated that Resident CR1 had a viral upper respiratory infection (URI, affecting the sinuses and throat). Physician orders included to obtain a chest x-ray.<br><br>A telephone physician's order from Employee 3 (certified registered nurse practitioner) dated January 20, 2025, at 10:57 AM instructed staff to obtain an oropharyngeal specimen (a type of sample collection method used in medical testing; it involves taking a sample from the middle part of the throat (pharynx) just beyond the mouth) for influenza (viral infection of the nose, throat and lungs) and COVID-19 testing.<br><br>A verbal physician's order from Employee 4 (physician) dated January 21, 2025, at 10:30 AM repeated an instruction for staff to obtain an oropharyngeal specimen for influenza testing.<br><br>A verbal physician's order from Employee 3 dated January 21, 2025, at 3:36 PM repeated an instruction for staff to obtain an oropharyngeal specimen for influenza testing.<br><br>Physician documentation by Employee 3 dated January 21, 2025, at 8:41 PM indicated that the chest x-ray dated January 20, 2025, for Resident CR1, showed mild CHF (congestive heart failure, inability of the heart to pump effectively, which results in the accumulation of fluid in the body), and Employee 3 ordered the administration of Lasix (a diuretic medication used to remove excess fluid from the body).<br><br>Resident CR1's closed clinical record contained no evidence that staff obtained an oropharyngeal specimen for influenza or COVID-19 testing.<br><br>(continued on next page) |

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

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

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Nursing documentation dated January 27, 2025, at 9:08 PM revealed that Resident CR1's daughter called the facility with concerns that Resident CR1 was declining (lethargic, decreased mental acuity, decrease in consciousness; not eating, grabbing for things that were not present in the room) and requested that the facility send Resident CR1 to the emergency room .<br><br>Nursing documentation dated January 27, 2025, at 9:18 PM indicated that the facility sent Resident CR1 to the emergency room .<br><br>Hospital Discharge Summary documentation dated February 5, 2025, revealed that Resident CR1 was admitted to the hospital on January 27, 2025, with diagnoses that included bilateral pulmonary embolus (blood clots in both lungs that block blood vessels within the lungs) with influenza A.<br><br>Interview with Employee 1 (registered nurse) and Employee 2 on February 27, 2025, at 1:45 PM, and Employee 1 on February 27, 2025, at 2:24 PM, confirmed the above findings for Resident CR1.<br><br>Clinical record review for Resident 1 revealed documentation by Employee 3 dated December 22, 2024, at 12:47 PM that Resident 1 had an overall decline, increased generalized weakness, poor appetite, and low blood sugars. Employee 3 informed the family that Resident 1 had not been eating or drinking well for the past couple of weeks. The decision was made to send Resident 1 to the emergency room .<br><br>Nursing documentation dated December 22, 2024, at 8:16 PM indicated that the emergency room staff admitted Resident 1 to the hospital.<br><br>A hospital History and Physical dated December 22, 2024, indicated that Resident 1's presenting problems were hyperkalemia (high blood potassium levels), AKI (acute kidney injury, a sudden decline in the ability of your kidneys to work and perform their normal functions), UTI (urinary tract infection), and pneumonia (lung infection).<br><br>Hospital Discharge Instructions dated December 29, 2024, instructed, Your medications have changed. Start taking Amlodipine (Norvasc, medication that lowers blood pressure by relaxing the blood vessels) on December 30, 2024. Stop taking Digoxin (medication used to help make the heart beat stronger and with a more regular rhythm) 125 mcg (micrograms), Lisinopril (medication used to lower blood pressure) 5 mg (milligrams), Metformin ER (medication used to lower blood sugar) 500 mg, and potassium chloride (mineral supplement used to prevent or to treat low blood levels of potassium) ER 10 mEq (milliequivalents).<br><br>Physician progress note documentation by Employee 2 dated December 30, 2024, at 9:58 AM stipulated that the facility readmitted Resident 1 on December 29, 2024, and that a Medicine reconciliation and management was also done. I obtained and reviewed the discharge information. I reviewed the need for diagnostic tests/treatments and/or follow up on pending diagnostic tests/treatment. The same documentation indicated a continuation of the medications Metformin, Digoxin, and Lisinopril.<br><br>Interview with Employee 2 on February 27, 2025, at 1:45 PM revealed that the December 29, 2024, discharge instructions for Resident 1 did not include a dated initial from him, which is his customary practice after reviewing hospital discharge orders. Employee 2 stated that he may not have had this document at the time of his review of Resident 1 when she returned to the facility after her hospitalization .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident 1's medication administration record (MAR, electronic documentation of the administration of medications) dated December 2024, revealed that staff continued to administer the following medications upon Resident 1's readmission from the hospital:<br><br>Digoxin 125 mcg in the morning every other day<br><br>Lisinopril 5 mg daily<br><br>Metformin ER 500 mg daily<br><br>Potassium chloride ER 20 mEq daily<br><br>The MAR did not indicate the start of the medication, Amlodipine.<br><br>Nursing documentation dated February 13, 2025, at 4:47 PM indicated that Resident 1 was in her room yelling for help. Resident 1 was lethargic with confusion and stated that she did not feel well but could not explain why. Her skin was dusky in color, she could not hold her head up, and she was incontinent of a very large liquid stool.<br><br>Nursing documentation dated February 14, 2025, at 12:11 AM revealed that Resident 1's blood pressure was low at 86/48 mm Hg (millimeters of mercury, the American Heart Association outlines a normal blood pressure reading of 130/80 mm Hg for adults.), her heart rate was low at 28 (The American Heart Association outlines a target heart rate for someone [AGE] years old or older as 75 to 128 beats per minute, bpm), she was pale in color, with increased respiratory effort, oxygen saturation was low on room air at 89 percent (normal oxygen saturation is greater than 90 percent). The writer contacted a provider on call who instructed staff to send Resident 1 to the hospital for evaluation. EMS (emergency medical service) personnel arrived at Resident 1's room and Resident 1's heart rate on a monitor varied from 24 to 32 bpm, and her blood pressure was 70/50 mm Hg. Resident 1 was transported out of the facility by EMS staff at 11:45 PM, .in guarded condition.<br><br>Nursing documentation dated February 14, 2025, at 1:55 AM revealed that the hospital emergency department admitted Resident 1 for hyperkalemia (high blood potassium; potassium level was 8.8), and AKI with BUN of 96 mg/dL (blood urea nitrogen, test to measure the amount of urea nitrogen in your blood to see how well the kidneys are working, normal 6 to 20 milligrams per deciliter); creatinine 3.8 mg/dL (waste product of muscle breakdown, normal 0.5 to 1.0 milligrams per deciliter); and GFR of 12 (glomerular filtration rate, measure of how well your kidneys are removing waste from your blood, normal greater than 60).<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of hospital cardiology consult documentation dated February 14, 2025, at 10:42 AM revealed that Resident 1 was seen regarding hypotension (low blood pressure) and bradycardia (slow heart rate). Pt (patient) was discharged from (the hospital) to (the nursing home) back in Dec (December) where her digoxin, lisinopril and potassium were to be stopped but in review of the (nursing home) MR (medical record) and medication administration these medications were still being given, which then resulted pt to become (sic) back to (the hospital) in CHB (complete heart block) with AKI and digoxin toxicity. Her digoxin level was not drawn until later in admission after getting IVF (intravenous fluids) and her HR (heart rate) and electrolytes and kidney function starting to improve. And her digoxin level was elevated still at 1.9 ng/mL (nanograms per milliliter), which makes me assume it was even higher on admission. Recent admission in December with severe AKI (acute kidney injury) on CKD (chronic kidney disease) and at that time digoxin and lisinopril were discontinued given hyperkalemia and bradycardia .review of her med list from the nursing home indicates that despite discontinuation request in December has still been receiving metformin, lisinopril, potassium and digoxin, which have contributed to her current level of renal failure .digoxin should be discontinued, given her renal failure should not ever be resumed.<br><br>The hospital discharge summary dated February 17, 2025, at 3:27 PM, noted that Resident 1 was found severely bradycardic with HR in the twenties. Resident 1 was also found to have severe hyperkalemia of 8.8 mm/L (normal 3.5 to 5.1 millimoles per liter). Resident 1's AKI on CKD with metabolic acidosis (condition where blood becomes too acidic) and digoxin toxicity had since resolved. Of note, patient was discharged from (the hospital) to nursing home in December and it was recommended to stop digoxin, lisinopril and oral potassium but per nursing MR and medication administrations this (sic) were still being given. Which may have contributed to patient's current presentation.<br><br>Interview with Employees 1 and 2 on February 27, 2025, at 1:45 PM confirmed that the facility did not implement Resident 1's hospital discharge physician orders for medication changes on December 29, 2024, and that staff continued to administer the medications until Resident 1's rehospitalization on [DATE].<br><br>483.25 Quality of Care<br><br>Previously cited deficiency 5/29/24<br><br>28 Pa. Code 211.2(d)(3) Medical director<br><br>28 Pa. Code 211.10(c) Resident care policies<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services |