

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/29/2024
NAME OF PROVIDER OR SUPPLIER  Greenwood Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  276 Green Ave Extended 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.

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>18229</p> <p>Based on review of select facility policies and procedures, review of employee personnel records, observation, and staff interview, it was determined that the facility failed to investigate a resident's injuries of unknown origin for one of 25 residents sampled (Resident 75) and failed to implement its abuse prohibition policy pertaining to screening for one of five newly hired employees reviewed (Employee 1).</p> <p>Findings include:</p> <p>Review of the facility policy entitled Abuse Prevention Program, last reviewed January 4, 2024, revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source (abuse) will be thoroughly investigated by facility management.</p> <p>The current facility policy entitled Abuse, Neglect, Exploitation, and Misappropriation last reviewed without changes on January 4, 2024, revealed that the facility will not tolerate abuse, neglect, exploitation of its residents or the misappropriation of resident property and will undertake background checks on all employees. Prior to hiring a new employee, the facility will conduct a criminal background check in accordance with Pennsylvania law and facility policy.</p> <p>Observation of Resident 75 on March 27, 2024, at 10:25 AM revealed a large purple bruise on Resident 75's left upper arm, a smaller bruise on her right upper arm, and a bruise to the top of Resident 75's right hand.</p> <p>An interview with the Nursing Home Administrator and Director of Nursing on March 29, 2024, at 10:41 AM revealed the facility had no evidence that they investigated Resident 75's bruises to rule out abuse.</p> <p>Review of Employee 1's, activity assistant, personnel record revealed that the facility hired her on December 20, 2023. Employee 1's personnel record did not reveal evidence that the facility completed a background check prior to hire and/or access to residents.</p> <p>This surveyor reviewed this information during an interview with the Director of Nursing on March 29, 2024, at 12:45 PM.</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.</p> <p>Previously cited 4/14/23.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29(a)(c) 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to notify a resident and/or their responsible party in writing of a transfer to the hospital for four of six residents reviewed (Residents 41, 60, 75, and 221).</p> <p>Findings include:</p> <p>Clinical record review for Resident 41 revealed that they were transferred to the hospital on November 8, 2023, after a change in their condition. There was no documentation that the facility provided written notification to the resident or the resident's responsible party regarding the transfer that included the required contents: the reason for the transfer, the effective date of the transfer, the location to which the resident was transferred, contact and address information for the Office of the State Long-Term Care Ombudsman, and information for the agency responsible for the protection and advocacy of individuals with developmental disabilities.</p> <p>Clinical record review for Resident 221 revealed that they were transferred to the hospital on March 1, 2024, after there was a change in their condition. There was no documentation that the facility provided written notification to the resident, or their responsible party as required regarding the transfer that included the required contents.</p> <p>The surveyor reviewed the above information for Residents 41 and 221 during an interview with the Director of Nursing on March 28, 2024, at 12:39 PM and March 29, 2024, at 11:19 AM.</p> <p>Clinical record review for Resident 75 revealed the resident was transferred and admitted to the hospital on December 30, 2023, returning to the facility on [DATE]. There was no evidence to indicate that Resident 75'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 75's transfer to the hospital.</p> <p>The Director of Nursing confirmed the above-noted findings regarding Resident 75's transfer notices during a meeting on March 29, 2024, at 11:35 AM.</p> <p>Clinical record review for Resident 60 revealed that the resident was transferred to the hospital and admitted on [DATE], returning to the facility on [DATE]. There was no evidence to indicate that Resident 60's responsible part was provided with written notification to include the above-required contents. Further review of facility documentation revealed that there was no evidence that the facility notified the Office of the State Long-Term Care Ombudsman of Resident 60's transfer to the hospital.</p> <p>The Director of Nursing confirmed the above-noted findings regarding Resident 60's transfer notices during a meeting on March 29, 2024, at 12:20 PM.</p> <p>28 Pa. Code 201.14 (a) Responsibility of license</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>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 - Some</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>29512</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 bed hold policy at the time of transfer for three of six residents reviewed for hospitalization s (Residents 41, 75, and 221).</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 41 was transferred to the hospital on November 8, 2023, after they had a change in condition. There was no documentation available that the facility provided written notice regarding a bed hold to the resident and/or the resident's responsible party upon transfer out to the hospital.</p> <p>Clinical record review revealed that Resident 221 was transferred to the hospital on March 1, 2024, after they had a change in condition. There was no documentation available that the facility provided written notice regarding a bed hold to the resident and/or the resident's responsible party upon transfer out to the hospital.</p> <p>The surveyor reviewed the above information for during an interview with the Director of Nursing on March 28, 2024, at 12:39 PM and March 29, 2024, at 11:19 AM.</p> <p>Clinical record review for Resident 75 revealed that she was transferred to the hospital on December 33, 2023, due to a fall. There was no documentation available that the facility provided written notice regarding a bed hold to the resident and/or Resident 75's responsible party upon transfer out of the facility.</p> <p>Interview with the Director of Nursing on March 29, 2024, at 11:35 AM confirmed that the facility did not provide a written bed hold notice to Resident 75 or his responsible party.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.29(f) Resident rights</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessments for one of 25 residents reviewed (Resident 110).</p> <p>Findings include:</p> <p>Review of Resident 110's clinical record revealed the facility admitted her on January 12, 2024. A review of Resident 110's admission Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated January 18, 2024, noted staff assessed Resident 110 as utilizing a limb restraint less than daily.</p> <p>Observation of Resident 110 on March 26, 2024, at 11:04 AM, and March 27, 2024, at 9:42 AM revealed no evidence of a limb restraint.</p> <p>Review of Resident 110's physician orders did not include evidence of Resident 110 utilizing a restraint.</p> <p>An interview with the Director of Nursing on March 28, 2024, at 10:52 AM confirmed the MDS was incorrect, and Resident 110 never utilized a restraint.</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36798</p> <p>Based on clinical record review and resident and staff interview, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan to maintain the highest practicable care for one of one resident reviewed (Residents 50).</p> <p>Findings Include:</p> <p>Clinical record review for Resident 50 revealed a psychiatry note dated [DATE], that indicated she wanted to die so she can be with her babies. The note indicated that she did not have a plan and that she stated she would never harm herself.</p> <p>Further review of the psychiatry note revealed that Resident 50 indicated that she mourns her son's death. She stated he died on e- and one-half days after he was born, and she never got to hold him. She also reported that she mourns the loss of multiple pregnancies that ended in miscarriage and cycles through the grieving process when the anniversary date of these events occurs. The note also indicated that she hears her deceased mother's voice and seeing her deceased mother from time to time.</p> <p>The note also indicated that a safety plan was developed, and the resident agrees to tell nursing staff should she begin to have feelings of suicidal ideation. The resident does not appear to be of immediate threat but recommends monitoring resident closely for any changes in condition or worsening of symptoms of depression.</p> <p>Review of Resident 50's current care plan revealed no evidence of a plan of care to address Resident 50's concerns related to wanting to die related to miscarriages and the death of her infant son and hearing her deceased mother's voice.</p> <p>Interview with the Director of Nursing on [DATE], at 10:34 AM confirmed the above noted findings related to Resident 50's care plan.</p> <p>The facility failed to implement a person center care plan to maintain the highest practicable care for Resident 50.</p> <p>28 Pa. Code 211.12(d)(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 - Few</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>36798</p> <p>Based on clinical record review and family and staff interview, it was determined that the facility failed to promote resident and/or responsible party involvement with care plan development for one of one resident reviewed (Resident 101).</p> <p>Findings include:</p> <p>Clinical record review for Resident 101 revealed that the facility conducted care plan meetings for her on August 4, 2023, September 6, 2023, and November 20, 2023.</p> <p>During a telephone interview with Resident 101's responsible party on March 26, 2024, at 1:51 PM she revealed that she only attended one care plan meeting and that she did not get invited to other ones. She indicated that she had to invite herself to the one she did attend by requesting a meeting.</p> <p>The Director of Nursing (DON) was made aware of the concern related to Resident 101's care plan meetings on March 27, 2024, at 2:00 PM.</p> <p>The Director of Nursing provided the surveyor with evidence that Resident 101's responsible party attended a meeting on March 18, 2024. The DON also confirmed at this time that this was a meeting that was requested by Resident 101's responsible party.</p> <p>Interview with the DON at 11:02 AM March 29, 2024, revealed that there was no evidence that Resident 101's responsible party was invited to attend her care plan meetings that were held on August 4, 2023, September 6, 2023, and November 20, 2023.</p> <p>The facility failed to promote resident and/or responsible party involvement with care plan development for Resident 101.</p> <p>483.21(b)(2)(E) Care Plan Timing and Revision</p> <p>Previously cited 4/14/23</p> <p>28 Pa. Code 211.10(a) Resident care policies</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36798</p> <p>Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to provide bathing assistance for residents dependent on staff assistance for five of six residents sampled for activities of daily living (Residents 52, 60, 64 and 96), and the facility failed to provide a resident with transfer assistance out of bed for a resident dependent on staff assistance, for one of six residents sampled. (Resident 92).</p> <p>Findings include:</p> <p>Clinical record review for Resident 60 revealed that he is to have a bed bath on Fridays dayshift due to wound dressings.</p> <p>Review of Resident 60's care plan for self-care deficit revealed that he required one assist with his activities of daily living. He also had a care plan intervention that indicated he was to receive a bed bath related to dressings on both of his lower legs.</p> <p>Review of Resident 60's task documentation (computerized documentation of care that is done for the resident) revealed that he did not have his complete bed bath on Friday March 1, 8, 15, or 22, 2024.</p> <p>Interview with the Director of Nursing on March 29, 2024, at 10:29 AM confirmed the above noted finding related to Resident 60's bathing.</p> <p>Clinical record review for Resident 96 revealed that the facility completed an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) on December 26, 2023, which indicated that she was not cognitively intact and that she needed partial to moderate assistance on staff to shower. Staff interviewed family who indicated that it was very important to choose between a tub bath, shower, bed bath, or sponge bath.</p> <p>Review of Resident 96's January, February, and March 2024, care plan documentation revealed that staff was to provide a bath on Mondays during day shift. Task documentation revealed that there was no documentation that staff provided a bath or shower to her.</p> <p>Observation of Resident 96 on March 27, 2023, at 11:08 AM revealed that she was in the activity room. Her hair was stringy and unkempt.</p> <p>Clinical record review for Resident 92 revealed that the facility completed a quarterly MDS on February 2, 2024, which indicated that she was cognitively intact, was diagnosed with multiple sclerosis, and that she was dependent on a staff member to complete transfers from the bed to chair.</p> <p>Interview with Resident 92 on March 26, 2024, at 12:45 PM revealed that she transfers via a Hoyer lift (a device to lift a person) out of bed and would like to be out of bed by 10:00 AM daily, but frequently has to wait until second shift staff arrive to get out of bed. She indicated that it was after 2:00 PM yesterday (March 25, 2024) until staff were able to get her up.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of and interview with Resident 92 on March 27, 2024, at 11:41 AM revealed that she was still in bed. She indicated that she would like to get up into her chair but would probably be evening shift until they (staff) get her up.</p> <p>Interview with the Nursing Home Administrator and the Director of Nursing on March 27, 2024, at 1:45 PM and with the Director of Nursing on March 29, 2024, at 11:17 AM acknowledged that staff were not getting residents up timely, and that staff were not providing showers or baths to residents.</p> <p>In an interview with Resident 64 on March 26, 2024, at 1:21 PM, the resident stated she had been doing things for herself at the facility. Resident 64 stated, If they think I am getting 24-hour care here, I am not. Resident 64 continued stating she has washed up in the bathroom and has not had an actual shower in five weeks, and she likes showers. Resident 64 stated she was aware everyone had their night to get one but was not sure what happened. The resident stated she has been given a basin in her room and has just washed up in her bathroom.</p> <p>Clinical record review for Resident 64 revealed a 5-day MDS dated [DATE], that revealed facility staff assessed the resident as requiring partial/moderate assistance with shower/bathing.</p> <p>Further clinical record review for Resident 64 revealed the resident had a scheduled task to receive a shower/bath every Wednesday evening shift since January 22, 2024.</p> <p>A review of Resident 64's bathing records report obtained March 28, 2024, for the last 30 days, revealed no data found. There was no evidence to indicate Resident 64 had received a shower, been offered a shower, or refused a shower in the last 30 days.</p> <p>An observation of Resident 52 on March 26, 2024, at 1:35 PM revealed the resident was in bed. Resident 52's hair appeared greasy with extensive dandruff and flaking and peeling skin throughout his hair. Resident 52 indicated he believed he was to be showered twice a week, and then thought it may have changed to Tuesdays, but did not recall his last shower. Resident 52 indicated he had seen a dermatologist prior and was supposed to use a special shampoo.</p> <p>A review of Resident 52's physician orders revealed the resident was ordered Nizoral External Shampoo 2% (a medicated shampoo to treat dandruff) to be applied to the scalp topically every evening shift Mondays, Wednesdays, and Fridays for dandruff. A review of Resident 52's treatment record for March 2024, revealed Resident 52 had only received the shampoo March 20, 2024, and was documented as refused all other times.</p> <p>A review of the manufacturer instructions for use of the Nizoral shampoo indicated it was to be applied to wet hair and scalp, lathered, left on for 3-5 minutes and rinse thoroughly.</p> <p>Clinical record review for Resident 52's quarterly MDS dated [DATE], revealed facility staff assessed the resident as requiring substantial/maximum assistance to shower/bathe.</p> <p>A review of Resident 52's bathing schedule and preference per the resident's task list in the resident's electronic record revealed the resident had two shower tasks listed, one to receive shower/baths every Wednesday and Saturday day shift, and another to receive a shower/bath every Wednesday evening shift.</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 - Few</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide services to maintain a resident's range of motion for one of 5 residents reviewed (Resident 44).</p> <p>Findings include:</p> <p>Clinical record review revealed a quarterly MDS (Minimum Data Set, an assessment completed at specific intervals to determine resident care needs) dated August 2, 2023, noting staff assessed Resident 44 as having no upper or lower extremity impairments.</p> <p>Review of physical therapy documentation revealed Resident 44 was discharged from physical therapy on August 4, 2023. A review of Resident 44's physical therapy discharge summary revealed his prognosis to maintain his current level of function would be good with consistent staff follow-through. The physical therapy discharge summary noted the facility does not offer restorative nursing programs.</p> <p>Further review of Resident 44's clinical record revealed his next quarterly MDS assessment dated [DATE], nursing staff assessed Resident 44 as having a limited range of motion to his bilateral lower extremities. Nursing staff again assessed Resident 44 as having a limited range of motion to his bilateral lower extremities on his most recent annual MDS assessment dated [DATE].</p> <p>The facility failed to ensure Resident 44 received appropriate treatment and services to maintain his range of motion (ROM, movement of the body to maintain a resident's ability) or prevent further decrease in his range of motion.</p> <p>An interview with Employee 4 (director of rehabilitation) confirmed he was not made aware of Resident 44's decline in range of motion. He also confirmed that the facility does not have a restorative nursing program to maintain residents' level of function when discharged from therapy services.</p> <p>The findings for Resident 44 were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on March 28, 2024, at 2:15 PM</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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NAME OF PROVIDER OR SUPPLIER  Greenwood Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 276 Green Ave Extended 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38839</p> <p>Based on observation, review of select facility policies, facility documents, clinical record review, and staff and resident interview, it was determined that the facility failed to implement appropriate interventions to prevent falls for one of five residents reviewed for falls (Resident 52).</p> <p>Findings include:</p> <p>In an interview an observation of Resident 52 on March 26, 2024, at 1:33 PM the resident was observed in bed with several steri strips (strips used to heal wounds by pulling two sides of a wound together) on his left hand. Resident 52 stated he fell out of bed a couple days ago.</p> <p>Clinical record review for Resident 52 revealed a nursing note dated March 20, 2024, at 4:11 PM, which noted when the resident was being changed, the resident rolled out of bed, landed on his knees, then rolled onto his right side, and hit his head on the wheel of the bed. It was also noted the resident's knees were red and excoriated, and a hematoma was present on the left side of his head.</p> <p>A nursing note dated March 21, 2024, at 1:14 AM for Resident 52 noted the resident's hand was assessed status post fall, and a 5 cm (centimeter) by 4.3-centimeter skin tear was noted to the back of the resident's left hand, and the resident stated he got it from the fall. It was noted the area was cleansed and steri strips were applied to all edges.</p> <p>A review of facility documentation of the incident dated March 20, 2024, at 5:42 PM indicated a nurse aide was providing care of the resident while in bed and the resident rolled out of the bed away from the nurse aide. An attached staff statement noted the staff member was providing incontinence care to the resident and the call bell came out of the wall, so the staff member turned to plug it back in and when she turned back toward the resident he was on the floor. The staff member noted the resident was getting his brief changed at the time of the incident.</p> <p>A review of a quarterly MDS (minimum data set, an assessment completed at periodic intervals of time to assess resident care needs) completed on February 10, 2024, revealed facility staff assessed the resident as being dependent on staff to roll left and right, dependent on staff for hygiene, and the resident had impaired range of motion on both upper extremities. Further review of a state only MDS assessment of the same date, facility staff assessed the resident as requiring extensive assistance of two plus person physical assistance for bed mobility.</p> <p>Further clinical record review for Resident 52 revealed a physician's order listed under behaviors dated February 14, 2023, indicating the resident is to have two people in the room at all times with care.</p> <p>Review of documentation did not indicate whether Resident 52 was demonstrating any behaviors at the time of the incident, but it was evident that care was being provided at the time of the incident when a nurse aide turned away to attend to a different task. There was no evidence to indicate another staff member was present as ordered for two for care as a behavioral intervention. Resident 52 did roll out of bed while receiving care and sustained minor injuries.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The above information was reviewed with the Director of Nursing on March 29, 2024, at 11:00 AM.</p> <p>483.25(d)(1)(2) Free of Accident Hazards</p> <p>Previously cited 4/14/23</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>36798</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to assess and implement individualized interventions to promote bowel and bladder continence for one of two residents reviewed for incontinence (Resident 115).</p> <p>Findings include:</p> <p>On March 29, 2024, at 12:35 PM The Director of Nursing (DON) indicated that the facility did not have a policy on evaluating resident bowel and bladder incontinence.</p> <p>Clinical record review for Resident 115 revealed a care plan that was initiated on March 4, 2024, that indicated she was incontinent of bowel and bladder.</p> <p>Further clinical record review for Resident 115 revealed a bowel and bladder program screener dated March 9, 2024, that indicated she was always continent of bladder and never incontinent of bowel.</p> <p>Care plans initiated March 4, 2024, indicated that Resident 115 is incontinent of bowel and incontinent of bladder.</p> <p>Review of Resident 115's task documentation (computerized documentation of the care provided) revealed that Resident 115 was documented as being incontinent of bowel 15 times and bladder 15 times from March 3 to 27, 2024.</p> <p>Review of Resident 115's most recent MDS (Minimum Data Assessment, an assessment performed by the facility at intervals to document care needs) dated March 3, 2024, revealed that Resident 115 was occasionally incontinent of bowel and frequently incontinent of bladder. The MDS also indicated that Resident 115 had a BIMS (Brief interview for mental status, an assessment used to monitor cognition) score of 15 indicating she was cognitively intact.</p> <p>Interview with the Director of Nursing on March 29, 2024, at 12:35 PM confirmed the above noted inconsistencies related to Resident 115's bowel and bladder continence. She confirmed that there was no evidence that the facility further assessed Resident 115 to implement interventions to promote bowel and bladder continence.</p> <p>The facility failed to appropriately assess and implement individualized interventions to promote bowel and bladder continence for Resident 115.</p> <p>28 Pa. Code 21.12(d)(1)(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 and staff interview, it was determined that the facility failed to implement interventions to promote acceptable parameters of nutrition for one of six residents reviewed (Resident 42).</p> <p>Findings include:</p> <p>Clinical record review revealed the facility admitted Resident 42 on January 23, 2024. Further review of Resident 42's clinical record revealed the following weight assessments:</p> <p>January 23, 2024, 145 pounds</p> <p>January 29, 2024, 127.8 pounds (a 17.2 pound, an 11.8 percent severe weight loss)</p> <p>January 30, 2024, 127.8 pounds</p> <p>February 2, 2024, 127.0 pounds</p> <p>February 7, 2024, 124.2 pounds</p> <p>February 13, 2024, 122.6 pounds</p> <p>Further review of Resident 42's clinical record revealed a nutrition progress note dated January 30, 2024, which noted resident showing a weight loss, request a re-weight.</p> <p>A nutrition progress note dated January 31, 2024, revealed Resident 42 was noted to have a 16.8-pound weight loss over seven days. The registered dietician recommended fortified foods for added calories for weight stabilization. An addendum was added to the note indicating Resident 42 has an allergy to lactose and recommends double protein portions at meals for Resident 42, instead of fortified foods.</p> <p>A nutrition progress note dated February 14, 2024, noted Resident 42 continues with slow weight loss.</p> <p>Review of Resident 42's clinical record revealed no evidence that the facility implemented the registered dietician's recommendation of double protein portions at meals.</p> <p>An interview with Employee 5 (assistant director of nursing) on March 29, 2024, at 10:37 AM confirmed the above findings for Resident 42 and stated the facility had no further documentation addressing Resident 42's severe weight loss.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>18229</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for one of three residents reviewed (Resident 75).</p> <p>Findings include:</p> <p>Observation of Resident 75 on March 27, 2024, at 9:39 AM revealed Resident 75 was in her room with oxygen on and running at 3 liters per minute.</p> <p>Observation of Resident 75 on March 27, 2024, at 10:28 AM revealed she was in the dining room without oxygen. Further observation revealed Resident 75's oxygen was running in her room at 3 liters per minute, with the nasal cannula tubing lying across Resident 75's bed.</p> <p>Review of Resident 75's clinical record revealed there was no physician's order for Resident 75 to receive oxygen.</p> <p>An interview with Employee 5 (assistant director of nursing) confirmed the above findings for Resident 75. Employee 5 indicated she was unsure when staff began administering Resident 75's oxygen but noted documentation in Resident 75's clinical record that Resident 75 utilized oxygen starting on March 22, 2024. Nursing staff obtained an order for Resident 75's oxygen after the surveyor's questions on March 27, 2024.</p> <p>The above findings regarding Resident 75 were reviewed with the Nursing Home Administrator and Director of Nursing on March 27, 2024, at 2:00 PM.</p> <p>28 Pa. Code 211.12(d)(1)(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 - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>29512</p> <p>Based on 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 one of four residents reviewed (Resident 91).</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 91 revealed physician's orders for the following pain medications:</p> <p>Ordered on April 20, 2023, Acetaminophen (Tylenol, for mild pain) 325 milligrams (mg) 2 tablets by mouth (PO) every 6 hours as needed (PRN) for pain 1-4.</p> <p>Ordered on August 8, 2023, and discontinued on July 15, 2024, Tramadol (for moderate to severe pain) 50 mg PO every 4 hours PRN for pain.</p> <p>Ordered on January 15, 2024, Tramadol (for moderate to severe pain) 50 mg PO every 4 hours PRN for pain 6-10.</p> <p>Review of Resident 91's August, September, October, November, and December 2023 and January, February, and March 2024 MAR (medication administration record, a form to document medication administration) revealed the following:</p> <p>Staff administered the following PRN pain medications:</p> <p>Acetaminophen 325 mg 2 tablets PO every 6 hours PRN for pain 1-4</p> <p>August 1, 2023, at 7:56 PM for a pain level of 5.</p> <p>August 2, 2023, at 8:15 PM for a pain level of 5.</p> <p>August 6, 2023, at 7:50 PM for a pain level of 5.</p> <p>August 11, 2023, at 8:26 PM for a pain level of 5.</p> <p>August 19, 2023, at 7:42 PM for a pain level of 5.</p> <p>August 20, 2023, at 4:18 AM for a pain level of 7.</p> <p>September 8, 2023, at 2:19 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 - Few</p>	<p>September 13, 2023, at 3:26 PM for a pain level of 8.</p> <p>October 18, 2023, at 4:32 PM for a pain level of 5.</p> <p>October 31, 2023, at 12:54 PM for a pain level of 5.</p> <p>November 13, 2023, at 7:41 PM for a pain level of 8.</p> <p>November 27, 2023, at 8:30 PM for a pain level of 7.</p> <p>November 28, 2023, at 8:01 PM for a pain level of 5.</p> <p>November 29, 2023, at 6:58 PM for a pain level of 5.</p> <p>December 3, 2023, at 8:10 PM for a pain level of 7.</p> <p>December 13, 2023, at 10:09 PM for a pain level of 7.</p> <p>December 15, 2023, at 8:26 PM for a pain level of 7.</p> <p>December 17, 2023, at 8:18 PM for a pain level of 6.</p> <p>December 27, 2023, at 9:02 PM for a pain level of 5.</p> <p>January 13, 2024, at 7:39 PM for a pain level of 7.</p> <p>February 3, 2024, at 8:02 PM for a pain level of 5.</p> <p>February 28, 2024, at 12:53 PM for a pain level of 5.</p> <p>March 4, 2024, at 8:04 PM for a pain level of 6.</p> <p>March 10, 2024, at 7:52 PM for a pain level of 6</p> <p>March 19, 2024, at 12:50 PM for a pain level of 5.</p> <p>March 23, 2024, at 7:45 PM for a pain level of 6.</p> <p>March 24, 2024, at 1:58 PM for a pain level of 6.</p> <p>Tramadol 50 mg PO every 4 hours PRN for pain 6-10</p> <p>February 5, 2024, at 7:34 PM for a pain level of 5.</p> <p>The surveyor reviewed Resident 91's pain information and not following the parameters during an interview with Employee 5, registered nurse, assistant director of nursing, on March 29, 2024, at 10:11 AM.</p> <p>(continued on next page)</p>

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F 0697  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	483.25(k) Pain Management  Previously cited 4/14/23  28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>38839</p> <p>Based on clinical record review, observations, and staff and resident interview, it was determined that the facility failed to ensure the availability of necessary emergency supplies for two out of three residents reviewed receiving hemodialysis (Residents 70 and 90).</p> <p>Findings include:</p> <p>Clinical record review for Resident 70 revealed the resident had an AV fistula (a connection that's made between an artery and a vein for dialysis access) in his left wrist for dialysis treatment.</p> <p>A physician's order for Resident 70 dated March 22, 2024, indicated the resident was to receive hemodialysis (a machine that performs a basic function of the kidney by cleansing the blood of impurities) every Tuesday, Thursday, and Saturday at a dialysis center. An additional physician's order dated March 22, 2024, indicated the resident was to have an emergency dialysis kit at bedside to contain two sterile 4x4's, hemostats (a tool used to control bleeding), and tape, and to replace the kit if needed.</p> <p>An observation and interview with Resident 70 on March 26, 2024, at 2:50 PM the resident stated he receives dialysis treatment every Tuesday, Thursday, and Saturday. Observation of the resident's room did not reveal any emergency kit visible in the room.</p> <p>Clinical record review for Resident 90 revealed the resident is ordered to receive hemodialysis on Tuesdays, Thursdays, and Saturdays, at a dialysis center as indicated in the resident's physician order dated March 21, 2024.</p> <p>A review of Resident 90's plan of care revealed the resident has an AV fistula in his left upper extremity and an emergency dialysis kit is to be kept as his bedside as added on March 22, 2024.</p> <p>An observation of Resident 90's room on March 26, 2024, at 1:48 AM did not reveal any visible emergency kit in the resident's room.</p> <p>A follow up observation of Resident 70's and Resident 90's room on March 27, 2024, at 10:55 AM with employee 6, licensed practical nurse, revealed no emergency kit in Resident 70 or Resident 90's room. Employee 6 indicated both residents had recently moved rooms and the emergency kits must not have moved with the residents.</p> <p>In an interview with the Nursing Home Administrator and Director of Nursing on March 27, 2024, at 2:20 PM the above findings regarding Resident 70 and Resident 90 were reviewed.</p> <p>28 Pa. Code 211.12 (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 - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36798</p> <p>Based on clinical record review and resident 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 eliminate or mitigate re-traumatization for one of one resident reviewed (Resident 50).</p> <p>Findings include:</p> <p>Clinical record review for Resident 50 revealed a quarterly Minimum Data Set (MDS, an assessment completed by the facility at intervals to determine care needs of the resident) assessment dated [DATE], that indicated she had an active diagnosis of PTSD (Post Traumatic Stress Syndrome, a mental and behavioral disorder that develops from experiencing a traumatic event).</p> <p>Interview with Resident 50 on [DATE], at 10:35 AM revealed that she has PTSD from being raped by her mom's brother and by her father, after her mother died . She also indicated that she was beaten in a past relationship.</p> <p>A psychiatric note dated [DATE], revealed that Resident 50 indicated she mourns the death of her son who died a day and a half after he was born. She indicated that she never got to hold him. She also mourns the loss of multiple pregnancies that ended in miscarriage and cycles through the grieving process when the anniversary date of these events occurs.</p> <p>Clinical record review of Resident 50's current care plan revealed a care plan problem that indicated she is at risk for adverse effects related to the use of antipsychotic (used to treat psychosis) medications for a diagnosis of anxiety (intense, excessive and persistent worry and fear about everyday situations) bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), schizophrenia (a serious mental illness that affects how a person thinks, feels and behaves), and PTSD. The care plan did not identify Resident 50's triggers that may retraumatize her related to her diagnosis of PTSD.</p> <p>Interview with the Director of Nursing on [DATE], at 11:00 AM confirmed the above noted findings related to Resident 50's diagnosis of PTSD.</p> <p>The facility failed to identify care plan triggers that may retraumatize Resident 50 related to her diagnosis of PTSD.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing services</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 29512</p> <p>Based on observation, clinical record review, and staff and family interview, it was determined that the facility failed to assess for the risk of side rail entrapment, for three of five residents reviewed for side rails (Residents 74, 104, and 105).</p> <p>Findings include:</p> <p>Clinical record review for Resident 105 revealed that she was admitted on [DATE], with an assessment that indicated she did not need to utilize side rails. On January 30, 2024, a physician ordered Resident 105 to utilize bilateral (both sides) side rails to (her) bed for positioning. There was no documentation after the January 30, 2024, order that indicated the bilateral side rails were assessed to ensure the side rails were appropriate and the resident's ability to utilize them.</p> <p>Observation of Resident 105 on March 26, 2023, at 12:03 PM revealed that she was dressed and sitting in a chair. There were bilateral side rails observed on the bed.</p> <p>The surveyor reviewed the above information during an interview with the Director of Nursing on March 29, 2024, at 11:19 AM.</p> <p>An observation of Resident 104 on March 26, 2024, at 12:47 PM revealed the resident was in bed. Enabler bars were observed on each side of the bed. A family member who was present indicated the resident does not use the bars to move in bed as she has no muscle ability to do so.</p> <p>Clinical record review for Resident 104 revealed a state only MDS (minimum data set assessment, an assessment completed at periodic intervals of time to assess resident care needs) dated March 1, 2024, in which facility staff assessed the resident as having a BIMS (brief interview of mental status) score of one, indicating severe cognitive impairment, and that the resident required extensive assistance of two plus persons for bed mobility.</p> <p>Further review revealed a siderail consent form dated July 28, 2023, one day after Resident 104 was admitted to the facility signed by Resident 104's responsible party, although a box indicating whether the responsible party did or did not consent to the rails was not checked.</p> <p>A side rail assessment form for Resident 104 completed on July 28, 2023, again one day after admission, revealed the resident was non-ambulatory, no history of falls, and no to the question of, Does the resident want the side rail raised.</p> <p>A side rail assessment dated [DATE], for Resident 104 indicated the resident was currently using the side rail for support or positioning, and the resident uses the side rail as an enabler to promote independence. There was no evidence to indicate Resident 104 had the physical ability to utilize an enabler bar.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no evidence facility staff assessed the enabler bars that were present on Resident 104's bed for the risk of entrapment.</p> <p>An observation of Resident 74 on March 27, 2024, at 10:42 AM revealed enabler bars on both sides of the resident's bed.</p> <p>Clinical record review for Resident 74 revealed a significant change MDS dated [DATE], in which facility staff assessed the resident as having a BIMS score of zero, indicating severe cognitive impairment, impairment on both sides of her upper body for range of motion, and dependent on staff for bed mobility. The review also identified the resident had a diagnosis of dementia since December 13, 2022.</p> <p>The last side rail assessment for Resident 74 completed by facility staff was dated July 21, 2023. The side rail assessment indicated that if a yes answer was indicated for any of the entrapment risk questions and the facility was still intending to prescribe bedrails, a clear reasoning must be documented. The first entrapment risk question listed as Does the resident have dementia, confusion, learning disability, agitation, unable to comprehend or distressed? was listed with an answer of no, despite the resident having a dementia diagnosis. The assessment also indicated a yes answer to the question, Does the resident refuse the use of bed rails? but also then noted dementia in the box as an alternative method.</p> <p>A quarterly MDS dated [DATE], near the time the last side rail assessment was completed and indicated staff assessed the resident as a BIMS of one, and extensive assistance of two plus person physical assist for bed mobility.</p> <p>There was no evidence to indicate Resident 74 could utilize the bilateral enabler bars observed on her bed or that any staff indicated the resident had the ability to utilize the enabler bars.</p> <p>In an interview with the Director of Nursing on March 29, 2024, at 11:00 AM the finding for Residents 104 and 74 were reviewed. The Director of Nursing indicated the side rail assessments appeared to be completed on admission and the enabler bars were just left on the resident's beds.</p> <p>483.25 (n) (1) (3) (4) Bed rails</p> <p>Previously cited 4/14/23</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>18229</p> <p>Based on review of facility documentation and staff interviews, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of residents with enteral tube feeding, catheter care, medication administration, and dressing changes for two of six employee competencies reviewed (Employees 11 and 12).</p> <p>Findings include:</p> <p>A review of the facility documentation revealed that the facility had a total of 124 residents receiving medications, 10 residents with indwelling catheters (insertion of a tube into the bladder to remove urine), six residents with pressure ulcers, and two residents with enteral tube feedings (device that allows liquid food to enter your stomach or intestine through a tube).</p> <p>A request for nursing staff competencies for enteral tube feeding, catheter care, medication administration, and dressing changes revealed the facility was unable to provide any for Employees 11 and 12 (licensed practical nurses).</p> <p>The findings were reviewed with the Nursing Home Administrator and Director of Nursing on March 28, 2024, at 2:55 PM. Further interview with the Director of Nursing on March 29, 2024, at 10:58 AM confirmed the facility could provide no documentation that ensured Employees 11 and 12 have specific competencies and skill sets to care for the residents' needs listed above.</p> <p>28 Pa Code 201.20(a) Staff development</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 four of four residents reviewed (Residents 17, 43, 44, 94).</p> <p>Findings include:</p> <p>Clinical record review for Resident 17 revealed the facility admitted her on July 19, 2022, with diagnoses including dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life). A review of Resident 17's most recent annual Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated June 9, 2023, indicated that the facility assessed Resident 17 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 17'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.</p> <p>Clinical record review for Resident 43 revealed the facility admitted him on July 11, 2020, with diagnoses including dementia. A review of Resident 43's Minimum Data Set assessment dated [DATE], indicated that the facility assessed Resident 43 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 43'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.</p> <p>Clinical record review for Resident 44 revealed the facility admitted him on June 9, 2022, with diagnoses including dementia. A review of Resident 44's most recent annual Minimum Data Set assessment dated [DATE], indicated that the facility assessed Resident 44 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 44'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.</p> <p>Clinical record review for Resident 94 revealed the facility admitted her on June 22, 2023, with diagnoses including dementia. A review of Resident 94's admission Minimum Data Set assessment dated [DATE], indicated that the facility assessed Resident 94 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 94'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.</p> <p>(continued on next page)</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>The findings were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on March 28, 2024, at 2:25 PM. Further interview with the Director of Nursing confirmed the facility had no further documentation that the facility developed and implemented an individualized person-centered care plan to address Residents 17, 43, 44, and 94's dementia and cognitive loss.</p> <p>28 Pa Code 211.12 (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 - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38839</p> <p>Based on observation and staff interview, it was determined the facility failed to store food to prevent the potential spread of food borne illness and maintain food service/storage equipment in a sanitary manner in the facility's main kitchen and one of three dining areas nursing units (100/300 dining room).</p> <p>Findings include:</p> <p>An observation of the facility's main kitchen on March 26, 2024, at 9:58 AM revealed the following:</p> <p>A large white bin next to the ice machine contained a white powdery substance. The bin was labeled as flour and dated September 7, 2023, with a use by date of March 7, 2024.</p> <p>An additional white bin next to the flour also contained a white powdery substance and was not labeled or dated. Employee 7, dietary manager, indicated it was thickener in the bin.</p> <p>An air vent on the front of the industrial ice machine was covered in dust on the exterior and interior of the vent.</p> <p>The lower shelf of a preparation table holding a food processor was dusty and contained dried particles on the shelf.</p> <p>A shelf extending from the wall over the above preparation table was observed with several plastic containers of spices on it. Debris from the various spice containers was observed all over the shelf. One container of rotisserie chicken seasoning was labeled with an open date of March 2, 2023, and expiration date of March 2, 2024.</p> <p>The walk-in cooler had several wire storage racks with food stored on them. Liners on the bottom shelf were soiled with dried liquid spots and dirt and debris. One lower shelf contained a cardboard box with packages of ground beef in the box. Pooled red liquid was observed in the bottom of the box. The shelf beside the box contained dried brown liquid spots.</p> <p>A clear plastic container labeled as corn meal was observed in the dry storage area with a use by date of January 4, 2024.</p> <p>A three-tier cart with food supplies on it was observed in the main production area where staff were observed cooking items on the stove top. The lower shelves of the cart contained dried food, debris, and dust.</p> <p>The lower shelf of the steam table area was dusty and contained crumbs and dried food.</p> <p>A metal storage rack located outside the dish room area across from the steam tables had visible dust hanging from the frame of the shelf throughout the rack.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Flooring throughout the kitchen under shelving units and equipment had a black buildup that was not visible in the main paths of the kitchen area.</p> <p>A vent unit in the hood of the dish machine was covered in thick dust buildup.</p> <p>The white wall behind the area of the dish machine where staff were observed placing dirty dishes into the machine was covered in a black buildup, which extended to the metal backsplash area.</p> <p>Observation of the walk-in freezer revealed several plastic storage bins labeled with various food items. Employee 7 indicated the items were leftovers saved for future use. Review of four of the containers revealed labels reading chicken noodle soup 3/14/24-4/14/24, broccoli cheese soup 3/18/24 - 4/18/24, beef tips 3/21/24-4/21/24, and smoked sausage 3/24/24-4/25/25. Concurrently upon review of the kitchen cool down log utilized for saving cooked products for future use, with Employee 7, there was no evidence that the products noted were cooled down in a manner to prevent the potential of food borne illness by assuring the food was cooled to 70 degrees Fahrenheit within two hours, and to 41 degrees Fahrenheit within 6 hours.</p> <p>Observation of the 100/300 hall dining room area revealed a refrigerator stored with items for resident use. The refrigerator had dried liquid spills in the door, lower shelf, and back wall of the refrigerator.</p> <p>The above findings were reviewed with the Nursing Home Administrator and Director of nursing on March 28, 2024, at 2:30 PM.</p> <p>483.60 (i)(2) Food storage safe and sanitary</p> <p>Previously cited 4/14/23</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36798</p> <p>Based on review of select policies and staff interview, it was determined that the facility failed to implement an effective Water Management Program for the prevention and control of water-borne contaminants, such as Legionella (a bacteria that may cause Legionnaires' Disease, a serious type of pneumonia).</p> <p>Findings include:</p> <p>The CDCs (Centers for Disease Control and Prevention) current Water Management Program Toolkit, Practical Guide to Implementing Industry Standards, indicated that many buildings need a water management program to reduce the risk for Legionella (bacteria that can grow and spread in water systems and can cause a serious type of pneumonia (lung infection) known as Legionnaires' disease) growing and spreading within their water system and devices. Developing and maintaining a water management program is a multi-step process that requires continuous review. Steps to building an effective Legionella water management program include:</p> <p>A description of the building's water system using flow diagrams and a written description to include details like connections to the municipal water supply, how water is distributed, and location of water heaters/boilers.</p> <p>Identification of potentially hazardous conditions such as areas where water temperature could promote Legionella growth or where water flow might be low.</p> <p>Control measures (such as heating, adding disinfectant, or cleaning) that include where and how to monitor them. Control limits are the maximum value, minimum value, or range of values that are acceptable for the control measure.</p> <p>Determine what corrective actions or contingency responses to take when control measures are outside the control limits established.</p> <p>Review of documents provided by Employee 3 (Director of Maintenance) on March 29, 2024, at 12:45 PM related to the facility's water management program revealed that the information provided was a source water assessment summary for the Municipal Authority of the [NAME] of Lewistown, Mifflin County for the month of November 2003.</p> <p>She also provided a document entitled, Pennsylvania Department of Environmental Protection Division of Drinking Water Management Maximum Contaminant Levels and Maximum Residual Disinfectant Levels that was dated April 2006.</p> <p>Concurrent interview of Employee 3 revealed that she did not have a flow diagram of the facilities water system. She also indicated that this was her first year back and that the information from the previous maintenance director could not be located.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On March 29, 2024, at 1:07 PM Employee 3 provided a document entitled, Legionella Water Management Plan [NAME] Village, dated February 30, 2024. The policy was missing page 2, and the facility did not provide the missing page when the surveyor inquired about it.</p> <p>Concurrent interview with Employee 3 revealed that the facility sends their water out to be tested as the [NAME] does not test for legionella. She stated that it was due by the end of April this year. Employee 3 indicated the results for last year's test were not available. She also indicated that she could not provide evidence that the facility identified areas of potentially hazardous conditions such as areas where water temperature could promote Legionella growth or where water flow might be low, control measures that include where and how to monitor them, control limits that are acceptable for the control measures, or corrective actions or contingency responses to take when control measures are outside the control limits.</p> <p>The surveyor reviewed the above concerns regarding the facility's water management program during a meeting with the Nursing Home Administrator on March 29, 2024, at 1:45 PM.</p> <p>The facility failed to develop and maintain a water management program to reduce the risk for Legionella growing and spreading within their water system and devices.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident care policy</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38839</p> <p>Based on clinical record review and staff and responsible party interview, it was determined that the facility failed to monitor antibiotic use for one of one resident reviewed for a urinary tract infection (Resident 74).</p> <p>Findings include:</p> <p>In an interview with a responsible party for Resident 74 on March 26, 2024, at 1:01 PM, the responsible party indicated the resident had been sick and had to go to the hospital as she had a urinary tract infection.</p> <p>Clinical record review for Resident 74 revealed the resident was sent to the emergency room from the facility on February 13, 2024, for abdominal pain, and not eating.</p> <p>Review of Resident 74's emergency room visit summary dated February 13, 2024, revealed the resident received multiple studies and lab work at the emergency room , which included a urinalysis with culture and sensitivity and results were pending. The resident was returned to the facility with a diagnosis of hypernatremia (an elevated sodium level), headache, and loss of appetite. Resident 74 received intravenous fluids at the emergency room and was returned to the facility with a change in an antipsychotic medication to be reviewed by psychiatry, but no other medication changes or additions. There was no diagnosis of a urinary tract infection listed on the report.</p> <p>A nursing note dated February 14, 2024, at 1:40 PM noted the resident was sent to the hospital last evening with a diagnosis of a urinary tract infection and the nurse practitioner was made aware and ordered extra fluids for 48 hours and directed nursing to wait for the culture and sensitivity results of the resident's urine to arrive.</p> <p>A late entry nurse practitioner note dated February 19, 2024, for February 16, 2024, at 2:03 PM noted Resident 74's emergency room visit, and that the resident was stable, and to continue medications and treatment regimen as ordered with no new orders. There was no mention of the urine culture and sensitivity or indication an antibiotic was needed.</p> <p>A review of the final culture and sensitivity report faxed and printed with a date of February 16, 2024, from Resident 74's urinalysis obtained at the emergency roiaqnom on [DATE], indicated a final result of no significant growth.</p> <p>A review of physician's orders for Resident 74 revealed the resident was ordered Macrobid (an antibiotic) 100 milligrams, by mouth two times a day for seven days for a urinary tract infection on February 18, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A late entry physician's note entered on March 15, 2024, for February 18, 2024, at 8:39 PM noted the resident had no issues or concerns since the last visit, and laboratory and imaging studies were reviewed and discussed with nursing with the resident's current medications reviewed, which did not include Macrobid or any antibiotic. The note indicated no changes or acute distress. There was no documentation to indicate the resident had a urinary tract infection or required the use of an antibiotic.</p> <p>A nursing note dated February 19, 2024, at 1:40 AM noted the resident was started on Macrobid for a urinary tract infection, and the resident is confused but had no current complaints of urinary discomfort or burning. Clinical record review for Resident 74 revealed a diagnosis of dementia since December 13, 2022.</p> <p>There was no physician documentation or evidence provided by the facility during the onsite visit to indicate why Resident 74 was ordered the Macrobid for a urinary tract infection on February 18, 2024, and the urine obtained during the emergency room visit on February 13, 2024, was cultured, and resulted in no growth.</p> <p>In an interview with the Director of Nursing on March 29, 2024, at 11:00 AM it was confirmed there was no information as to why Resident 74 was ordered the antibiotic as indicated above.</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 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>36798</p> <p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident received or was offered pneumococcal conjugate vaccines for one of five residents reviewed for immunization concerns (Resident 4).</p> <p>Findings include:</p> <p>Clinical record review for Resident 4 revealed that the facility admitted her on October 6, 2022.</p> <p>Further clinical record review revealed that the facility documented on admission that Resident 4 previously had a pneumovax 23 (a vaccine administered to prevent pneumonia) on March 1, 2007. There was no evidence in Resident 4's clinical record that indicated she was offered pneumococcal conjugate vaccines (vaccines that prevent against bacteria that cause pneumonia)</p> <p>Review of the document published April 1, 2022, by the Center for Disease Control and Prevention, entitled Pneumococcal Vaccine Timing for Adults, Resident 4 should have been offered a pneumococcal conjugate vaccine.</p> <p>Interview with Employee 2, Registered Nurse, Infection Preventionist, on March 29, 2024, at 12:30 PM confirmed the above noted findings for Resident 4.</p> <p>The facility failed to follow-up with the pneumococcal vaccinations for Resident 4 and ensure the resident received the appropriate vaccinations as recommended.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/29/2024
NAME OF PROVIDER OR SUPPLIER  Greenwood Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  276 Green Ave Extended 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>38839</p> <p>Based on review of facility staff education records and staff interview, it was determined that the facility failed to ensure that all nurse aide staff completed a minimum of 12 hours of in-service education training each year for three of three nurse aides reviewed (Employees 1, 2, and 3).</p> <p>Findings include:</p> <p>During an interview with the Nursing Home Administrator and the Director of Nursing on April 12, 2023, at 2:00 PM the surveyor requested evidence of annual in-service education for the three nurse aide staff as follows:</p> <p>Employee 8, nurse aide, hired March 14, 2022.</p> <p>Employee 9, nurse aide, hired December 7, 2021.</p> <p>Employee 10, nurse aide, hired January 31, 2022.</p> <p>Interview with the Director of Nursing on March 29, 2024, at 11:00 AM confirmed that the facility had no evidence of any in-service education for Employees 8, 9, or 10, that included dementia training, abuse prevention training, and any areas of weakness or resident special care needs in the past year.</p> <p>483.95 (g)(g 1-4) Training requirements</p> <p>Previously cited 4/14/23</p> <p>28 Pa. Code 201.18(b)(3) Management</p> <p>28 Pa. Code 201.20(a)(d) Staff development</p> <p>28 Pa. Code 211.12(c) Nursing services</p>		