

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Swaim Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 210 Big Spring Road Newville, PA 17241	

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 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>48484</p> <p>Based on facility policy review, record review, and staff interview, it was determined that the facility failed to ensure residents with limited mobility received appropriate services and assistance to maintain or improve mobility for one of two residents reviewed for limited range of motion (Resident 42).</p> <p>Findings include:</p> <p>Review of facility policy, titled Restorative Care Program, last reviewed August 15, 2023, read, in part, Presbyterian Senior Living facilities will provide restorative services which prevent, slow functional decline and/or maintain the resident highest practicable level functioning in accordance with state and federal regulations. Matrix Care Point of Care will be assigned for Nurse Aid documentation to include the program and the minutes the program is performed.</p> <p>Review of Resident 42's clinical record revealed diagnoses that included chronic pain (pain that lasts more than three months or beyond normal healing time), anxiety (a feeling of worry, nervousness, or unease), and left above the knee amputation.</p> <p>Review of Resident 42's care plan revealed she has restorative nursing programs in place for active range of motion to upper and lower extremities and dressing and grooming at 7:00 AM and 3:00 PM, daily.</p> <p>Review of Resident 42's point of care documentation failed to reveal minutes or tolerance documented for her restorative programs at 7:00 AM on July 4, 19, 24, and 31, 2024.</p> <p>Review of Resident 42's point of care documentation failed to reveal minutes or tolerance documented for her restorative programs at 3:00 PM on July 16, 2024; and August 1 and 13, 2024.</p> <p>Review of Resident 42's point of care documentation failed to reveal minutes or tolerance documented for her restorative programs at both 7:00 AM and 3:00 PM on July 21, 2024, and August 2, 2024.</p> <p>Interview with the Director of Nursing on August 14, 2024, at 2:02 PM, revealed she was unable to locate documentation to indicate Resident 42's restorative program was implemented or that she had refused it on the aforementioned dates. No further information was provided.</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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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>48484</p> <p>Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that the licensed pharmacist's report of a medication irregularity was reviewed and acted upon timely for two of five residents reviewed for unnecessary medications (Residents 5 and 42).</p> <p>Findings include:</p> <p>Review of facility policy, titled Medication Regimen Review, last reviewed August 15, 2023, read, in part, The consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. The findings are phoned, faxed, or e-mailed within 24 hours to the director of nursing or designee and are documented and stored with the other consultant pharmacist recommendations in the resident's active record. The prescriber is notified if needed.</p> <p>Review of facility policy, titled Documentation and Communicating of Consultant Pharmacists Recommendations, last reviewed August 15, 2023, read, in part, The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapies are communicated to those with authority and/or responsibility to implement the recommendations, and are responded to in an appropriate and timely fashion. Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review. Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to the recommendation directed to him/her within 30 days, the Director of Nursing and/or the consultant pharmacist may contact the Medical Director.</p> <p>Review of Resident 5's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), anxiety (a feeling of worry, nervousness, or unease), and osteoarthritis (a condition that causes the breakdown of cartilage in the joints, leading to pain and stiffness).</p> <p>Review of Resident 5's clinical record revealed a Medication Regimen Review (MRR) document dated May 27, 2024, that stated Resident is receiving Bisphosphonate (medication). Please consider the addition of a calcium supplement and/or vitamin D supplement to medication regimen. The physician was noted to agree with the recommendation and wrote an order for Calcium 500 mg + Vitamin D 500 IU twice daily, and signed and dated June 27, 2024. Further review of Resident 5's MRR document revealed the notation that the medication was ordered on July 12, 2024.</p> <p>During an email correspondence with the Director of Nursing (DON) on August 14, 2024, at 9:45 AM, she revealed they did not receive the pharmacy recommendation from the pharmacist until around June 10, 2024, at that time it was provided to their Medical Director (MD) for completion. The MD did not return the MRR to the DON until July 12, 2024, and the DON put the order in herself. She further revealed verbal education was provided to the MD at that time about the importance of timeliness of completion and return of MRR's.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DON on August 14, 2024, at 12:13 PM, revealed pharmacy sends their MRR's over in an email and sometimes they are secured, and the facility is unable to open them which delays the process, or pharmacy sends them over late. She further revealed the facility is working on a better process for timely delivery and responses to MRR's.</p> <p>Review of Resident 42's clinical record revealed diagnoses that included chronic pain (pain that lasts more than three months or beyond normal healing time), anxiety, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in things).</p> <p>Review of Resident 42's clinical record revealed a MRR dated November 30, 2023, noting that Resident 42's lorazepam (medication for anxiety) was due for an assessment related to the regulations for a gradual dose reduction, and that if there is no dosage reduction indicated, please provide the clinical rationale. The rationale for no dosage reduction was provided and signed by the physician on January 4, 2024.</p> <p>Email correspondence with the DON on August 14, 2024, at 12:16 PM, she revealed the response from the physician was delayed because the facility did not receive the aforementioned MRR from pharmacy until December 20, 2023.</p> <p>28 Pa. Code 211.2(d)(3) Physician services</p> <p>28 Pa Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa. Code 211.10(a)(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48484</p> <p>Based on observations, review of select facility documentation, and staff interviews, it was determined that the facility failed to monitor and utilize equipment in accordance with professional standards for food service safety in the main kitchen and cafe area.</p> <p>Findings include:</p> <p>Observation of the dish machine in the main kitchen on August 12, 2024, at 9:36 AM, revealed the wash cycle temperature was reading 150 degrees Fahrenheit (F- unit of measure) and the rinse cycle temperature was reading 172 degrees F.</p> <p>During an interview with Employee 1 (Food Service Director) on August 12, 2024, at 9:38 AM, he revealed it is possible the machine needs to heat up more for the day before it reaches the minimum acceptable temperatures.</p> <p>Observation of the August 2024 dish machine temperature log on August 12, 2024, at 9:40 AM, revealed the recorded wash cycle temperatures were below the minimum safe temperature of 160 degrees F on August 1-3, 2024, during breakfast; and August 2, 3, and 5, 2024, during lunch.</p> <p>Further observation of the August 2024 dish machine temperature log on August 12, 2024, at 9:40 AM, revealed the recorded rinse cycle temperatures were below the minimum safe temperature of 180 degrees F on August 5 and 11, 2024, during lunch. The temperature log notes if the wash temperature is below 160 F or final rinse below 180 F, notify a manager immediately and record corrective action taken. No corrective action was noted for any of the aforementioned dates.</p> <p>Observation of the dish machine in the main kitchen on August 12, 2024, at 12:57 PM, revealed the wash cycle temperature was reading 142 degrees F and the rinse cycle temperature was reading 175 degrees F.</p> <p>Interview with Employee 2 (Dietary Employee) on August 12, 2024, at 12:58 PM, revealed they are waiting to run the dish machine for the rest of the dishes from lunch since it is not running at the proper temperature.</p> <p>Follow-up interview with Employee 1 on August 12, 2024, at 1:04 PM, revealed he would investigate the issue with the dish machine.</p> <p>Review of the December 2023 kitchen refrigerator and freezer temperature log revealed temperatures failed to be recorded on December 28 and 29, 2023, in the PM; and December 31, 2023, in the AM.</p> <p>Review of the December 2023 ice cream freezer and [NAME] refrigerator temperature log revealed temperatures failed to be recorded on December 28, 20243 in PM; December 30, 2023, in AM and PM; and December 31, 2023, in AM.</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 - Some</p>	<p>Review of the February 2024 [NAME] refrigerator and reach in freezer temperature log revealed temperatures failed to be recorded for the [NAME] refrigerator in the PM on February 2, 16, 18, 19, and 29, 2024; the reach in freezer in AM and PM on February 2, 2024; and in PM on February 16, 18, and 29, 2024.</p> <p>Review of the February 2024 kitchen refrigerator and freezer temperature log revealed temperatures failed to be recorded on February 2, 2024, in AM and PM; and February 8, 9, 16 and 29, 2024, in PM.</p> <p>Review of the February 2024 cafe refrigerator and freezer temperature log revealed temperatures failed to be recorded in AM and PM on February 3, 4, 6, 24, 25, and 28, 2024.</p> <p>Review of the May 2024 [NAME] refrigerator and reach in freezer temperature log revealed temperatures failed to be recorded in the PM on May 17 and 24, 2024.</p> <p>Review of the May 2024 kitchen refrigerator and freezer temperature log revealed temperatures failed to be recorded in the PM on May 17 and 24, 2024.</p> <p>Review of the May 2024 dish machine temperature log revealed the recorded wash cycle temperatures were below the minimum safe temperature on May 3 and 4, 2024, during breakfast; and May 5-7, 2024, during lunch; the log failed to reveal wash or rinse cycle temperatures during dinner shift on May 2-14, 22, 28-30, 2024; and failed to reveal corrective action noted for the temperatures outside of acceptable range.</p> <p>Review of the June 2024 [NAME] refrigerator and reach in freezer temperature log revealed temperatures failed to be recorded in the PM on June 7, 29, and 30, 2024; and in AM on June 21, 2024.</p> <p>Review of the June 2024 kitchen refrigerator and freezer temperature log revealed temperatures failed to be recorded in the AM on June 7, 2024, and in the PM on June 21, 2024.</p> <p>Review of the June 2024 cafe refrigerator and freezer temperature log revealed temperatures failed to be recorded in AM and PM on June 22 and 23, 2024.</p> <p>Review of the June 2024 dish machine temperature log revealed the recorded wash cycle temperatures were below the minimum safe temperature on June 20-24 and 26, 2024, during breakfast; June 23-26 and 30, 2024, during lunch; and June 27, 2024 during dinner shift. The log failed to reveal corrective action noted for the temperatures outside of acceptable range.</p> <p>Review of the July 2024 [NAME] refrigerator and reach in freezer temperature log revealed temperatures failed to be recorded in the PM on July 28 and 31, 2024.</p> <p>Review of the July 2024 kitchen refrigerator and freezer temperature log revealed temperatures failed to be recorded in the PM on July 5 and 28, 2024.</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 - Some</p>	<p>Review of the July 2024 dish machine temperature log revealed the recorded wash cycle temperatures were below the minimum safe temperature on July 8, 12, 17, 24, 28, and 30, 2024, during breakfast; July 8-10, 12-14, 16, 17, 28, and 29, 2024, during lunch; and July 12, 2024, during dinner shift. The recorded rinse cycle temperature was below the minimum safe temperature on July 28, 2024, during lunch; and the log failed to reveal corrective action noted for the temperatures outside of acceptable range.</p> <p>Review of select facility invoice dated August 12, 2024, revealed the dish machine was in need of repair and was fixed that evening.</p> <p>Interview with the Nursing Home Administrator on August 14, 2024, at 12:17 PM, revealed her expectation for kitchen equipment to be utilized and monitored in accordance with professional standards.</p> <p>28 Pa. Code 211.6(f) Dietary services</p> <p>28 Pa. Code 201.18(b)(3)(e)(2.1) Management</p>