

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/15/2024
NAME OF PROVIDER OR SUPPLIER  Wecare at Sycamore Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE  1445 Sycamore Road Montoursville, PA 17754	

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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to notify a resident and/or the resident's responsible party in writing of a transfer to the hospital for seven of 10 residents reviewed (Residents 3, 34, 69, 44, 62, 45, and 10). The facility also failed to notify the Office of the State Long-Term Care Ombudsman of a transfer to the hospital for 3 of 10 residents reviewed (Residents 34, 44, and 69).</p> <p>Findings include:</p> <p>A review of Resident 3's clinical record revealed that the facility transferred her to the hospital from November 11 to 13, 2023. There was no documented evidence to indicate that the facility provided a written notice to Resident 3's responsible party regarding her transfer to the hospital that included the required contents: reason for the transfer, effective date of the transfer, location to which the resident was transferred to, contact and address (mailing and email) information for the Office of the State Long-Term Care Ombudsman, and information (mailing and email address and telephone number) for the agency responsible for the protection and advocacy of individuals with developmental disabilities, and a statement of resident's appeal rights, including name, address (mailing and email) and telephone number of entity which receives requests.</p> <p>A clinical record review for Resident 34 revealed he was transferred to the hospital from December 16 to 21, 2023, for a change in condition and was admitted . There was no evidence to indicate that Resident 34'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 34's transfer to the hospital.</p> <p>A clinical record review for Resident 44 revealed he was transferred to the hospital from December 18 to 21, 2023, for a change in condition and was admitted . There was no evidence to indicate that Resident 44'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 44's transfer to the hospital.</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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>A clinical record review for Resident 69 revealed he was transferred to the hospital from December 28, 2023, to January 2, 2024. There was no evidence to indicate that Resident 69'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 69's transfer to the hospital.</p> <p>The surveyor reviewed the above information for Residents 3, 34, 44, and 69 during an interview with the Nursing Home Administrator Director of Nursing on March 14, 2024, at 2:20 PM.</p> <p>Clinical record review for Resident 10 revealed that she was transferred to the hospital on December 13, 2023, for respiratory distress. There was no evidence to indicate that Resident 10's responsible party was provided written notification to include the above-required contents.</p> <p>Clinical record review for Resident 45 revealed that she was transferred to the hospital on December 27, 2023, related to pneumonia. There was no evidence to indicate that Resident 45's responsible party was provided written notification to include the above-required contents.</p> <p>Clinical record review for Resident 62 revealed that he was transferred to the hospital on October 31, 2023, related to concerns with swelling around his dialysis (a process that helps your body remove extra fluid and waste when your kidneys are not able to) fistula (a surgical connection that is made between an artery and a vein for dialysis access).</p> <p>There was no evidence to indicate that Resident 62's responsible party was provided written notification to include the above-required contents.</p> <p>The Nursing Home administrator confirmed the above noted findings regarding transfer notices during a meeting on March 14, 2024, at 2:40 PM.</p> <p>The surveyor reviewed the above noted findings for Residents 10, 45, and 62, during a meeting with the Nursing Home Administrator and Director of Nursing on March 14, 2024, at 2:45 PM.</p> <p>28 Pa. Code 201.14(a) Responsibility of license</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - 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>36798</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident or resident representative received written notice of the facility's bed hold policy at the time of transfer for six of 10 residents reviewed for hospitalization s (Residents 3, 10, 44, 45, 62, and 69).</p> <p>Findings include:</p> <p>Clinical record review for Resident 10 revealed that she was transferred to the hospital on December 13, 2023, for respiratory distress. 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 of the facility.</p> <p>Clinical record review for Resident 45 revealed that she was transferred to the hospital on December 27, 2023, related to pneumonia. 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 of the facility.</p> <p>Clinical record review for Resident 62 revealed that he was transferred to the hospital on October 31, 2023, related to concerns with swelling around his dialysis (a process that helps your body remove extra fluid and waste when your kidneys are not able to) fistula (a surgical connection that is made between an artery and a vein for dialysis access). There was no documentation available that the facility provided written notice regarding a bed hold to Resident 62 and/or his responsible party upon transfer out of the facility.</p> <p>Clinical record review for Resident 3 revealed that she was transferred to the hospital on November 11 to 13, 2023, for a change in mental status. There was no documentation available that the facility provided written notice regarding a bed hold to Resident 3 and/or Resident 3's responsible party upon transfer out of the facility.</p> <p>Clinical record review for Resident 44 revealed that she was transferred to the hospital on December 18 to 21, 2023, for a change in his mental status. There was no documentation available that the facility provided written notice regarding a bed hold to Resident 44 and/or the Resident 44's responsible party upon transfer out of the facility.</p> <p>Clinical record review for Resident 69 revealed that she was transferred to the hospital on December 28, 2023, to January 2, 2024. There was no documentation available that the facility provided written notice regarding a bed hold to Resident 69 and/or Resident 69's responsible party upon transfer out of the facility.</p> <p>The facility failed to provide written notice of their bed hold policy at the time of transfer for Residents 3, 10, 44, 45, 62, and 69. The Nursing Home administrator confirmed the above-noted findings related to bed hold notices during a meeting on March 14, 2024, at 2:40 PM.</p> <p>(continued on next page)</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>19719</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to implement a comprehensive person-centered care plan regarding cognitive loss and psychotropic medication use with behaviors for two of 22 residents reviewed (Resident 64 and 75).</p> <p>Findings Include:</p> <p>Review of Resident 64's clinical record revealed a Minimum Data Set Assessment (MDS, an assessment done at specific intervals to determine care needs) dated May 12, 2023, revealed that the facility assessed Resident 64 as having cognitive loss and determined that a plan of care would be developed to address her cognitive loss.</p> <p>Review of Resident 64's current plan of care revealed that the facility did not develop a plan of care to address her cognitive loss until March 12, 2024.</p> <p>Interview with the Director of Nursing on March 15, 2024, at 9:32 AM, confirmed the above findings for Resident 64.</p> <p>Clinical record review for Resident 75, revealed her current physician orders to include the following psychoactive (medications that affects how the brain works and causes changes in mood, awareness, thoughts, feelings or behavior) medications: Xanax (a medication used to treat anxiety) 0.5 milligrams three times a day, Olanzapine (a medication used to treat schizophrenia), and Bupropion HCl (a medication used to treat depression).</p> <p>Review of Resident 75's current plan of care revealed that the facility did develop a personalized care plan for Resident 75 that identified her targeted behaviors and individualized interventions related to her mood and behaviors.</p> <p>Interview with Employee 7, Social Services, on March 15, 2024, at 10:31 AM, confirmed the above findings related to Resident 75.</p> <p>The Nursing Home Administrator was made aware of the concerns related to Resident 75's care plan on March 15, 2024, at 12:30 PM.</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - 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>29512</p> <p>Based on review of select facility policies, clinical record review, and staff and resident interview, it was determined that the facility failed to invite and ensure resident and responsible party attendance and to hold care plan conferences for three of 22 residents reviewed (Resident 8, 62, and 66).</p> <p>Findings include:</p> <p>Clinical record review for Resident 8 revealed that the facility documented a care plan note on February 15, 2023, to review and revise her plan of care. There was no documentation after February 15, 2023, that the facility completed a care plan meeting or invited Resident 8 and/or her responsible party to care plan meetings.</p> <p>Clinical record review for Resident 66 revealed that the facility completed a quarterly MDS MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) on January 16, 2024, and indicated that she was capable. The facility indicated that she was her own responsible party. On October 17, 2023, the facility documented a care plan meeting to review and revise her plan of care with Resident 66 and her sister attending. There was no documentation after October 17, 2023, that the facility completed a care plan meeting or invited Resident 8 and/or her responsible party to care plan meetings.</p> <p>During an interview with Resident 62, and his wife, on March 12, 2024, at 10:50 AM, the wife indicated that they were to attend a meeting at 11:00 the same day. She presented an invitation and it was noted that the meeting was a care plan meeting. She indicated that the facility holds care plan meetings once a year. There was no clinical documentation prior to the scheduled meeting of March 12, 2024, at 11:00 AM to indicate that the facility completed a care plan meeting or invited Resident 62 and/or her responsible party to care plan meetings within the past year.</p> <p>Interview with Employee 7, Social Services on March 15, 2024, at 12:45 PM, confirmed that she did not invite or hold any other care plan meetings over the past year with Resident 62.</p> <p>Interview with the Nursing Home Administrator on March 15, 2024, at 8:43 AM and 11:25 AM confirmed the above findings.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>29512</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician-ordered vital signs, medications, and interventions for two of 22 residents (Residents 8 and 52) and integrated hospice care and services for two of four residents reviewed (Residents 34 and 75).</p> <p>Findings include:</p> <p>Clinical record review for Resident 8 revealed a current physician order for staff to place an air mattress on her bed and monitor the air mattress every shift to ensure the pump setting was 220 (pounds) alternating pressure for skin protection.</p> <p>Observation of Resident 8's air mattress on March 12, 2023, at 9:54 AM, March 13, 2024, at 11:21 AM, and March 14, 2024, at 8:28 AM and 10:45 AM revealed that her air mattress pump setting was 380 pounds.</p> <p>Further clinical record review for Resident 8 revealed a physician order for staff to administer Detemir insulin 100 unit/milliliter 37 units subcutaneously (just under the skin) daily for diabetes. Staff were to hold the insulin if Resident 8's blood sugar was less than 100 mg/dl (milligrams/deciliter).</p> <p>Review of Resident 8's January, February, and March 2024 MAR (medication administration record, a form to document medication administration) revealed that there was no documentation that staff were monitoring Resident 8's blood sugars as ordered.</p> <p>Clinical record review for Resident 52 revealed a current physician order place a wide air mattress on his bed and monitor the air mattress every shift to ensure the pump setting was 450 (pounds) alternating pressure.</p> <p>Observation of Resident 52's air mattress on March 12, 2023, at 9:37 AM and 3:05 PM revealed that his air mattress pump setting was 540 pounds.</p> <p>The surveyor reviewed the above information during an interview on March 14, 2024, at 10:45 AM and 1:21 PM and March 15, 2024, 10:20 AM with the Nursing Home Administrator and Director of Nursing.</p> <p>Clinical record review for Resident 75 revealed that she was on Hospice related to a terminal diagnosis of malignant neoplasm of the endometrium (a disease in which cancer cells form in the tissues of the lining of the uterus).</p> <p>Review of Resident 75's current care plan revealed that the facility failed to implement an integrated plan of care with hospice services. The plan of care did not include evidence of all services that hospice will provide for the management of Resident 75's terminal illness.</p> <p>Resident 75's current care plan failed to identify the hospice entity providing services, the hospice disciplines that would provide her care and services, and how often.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Employee 7 (social services) confirmed the above-noted finding related to Resident 75's hospice services and plan of care during an interview on March 15, 2024, at 10:30 AM and confirmed that she updated Resident 75's care plan with hospice information after the surveyor brought this to her attention at 8:30 AM on March 15, 2024.</p> <p>Clinical record review revealed the facility admitted Resident 34 to hospice on December 30, 2023, due to a terminal diagnosis of end-stage dementia with a poor prognosis.</p> <p>Review of Resident 34's current care plan revealed that the facility failed to implement an integrated plan of care with hospice services. The plan of care did not include evidence of all services that hospice will provide for the management of Resident 34's terminal illness.</p> <p>Interview with Employee 7 on March 15, 2024, at 10:32 AM confirmed the above-noted findings for Resident 34. Resident 34's plan of care failed to delineate who was to provide for the physical, psychosocial, spiritual, and emotional needs of Resident 34.</p> <p>483.25 Quality of Care</p> <p>Previously cited 11/2/23 and 3/3/23</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18229</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to assess and implement treatment and services to prevent development and promote healing of pressure ulcers for four of six residents reviewed for pressure ulcer concerns (Residents 15, 22, 34 and 260).</p> <p>Findings include:</p> <p>Clinical record review for Resident 15 revealed wound clinic documentation date of March 14, 2024, which indicated that he had a chronic pressure ulcer on his left buttock measuring 2 centimeters by 2 centimeter by 3 centimeters.</p> <p>Resident 15's current physician order revealed that staff was to place an air mattress to his bed, ensure that it was set at 150 pounds, and provided alternating pressure.</p> <p>Observation of Resident 15 on March 12, 2024, at 10:01 AM revealed that he was in bed and his air mattress was set at 660-750 pounds.</p> <p>Clinical record review for Resident 22 revealed that the facility admitted her on September 25, 2023, with diagnoses of paraplegia (paralyzed lower extremities), a non-pressure chronic ulcer to her back, osteomyelitis, and extradural and subdural abscess. An admission assessment dated [DATE], revealed that Resident 22 had an unstageable pressure ulcer on her left buttock measuring 14.5 centimeters by 9 centimeters with eschar (blackened dead tissue).</p> <p>On March 8, 2024, staff documented that Resident 22 weighed 220.8 pounds.</p> <p>Resident 22's current physician orders indicated that staff was to place a pressure relieving mattress to her bed and monitor that it was functioning every night shift.</p> <p>Observation of Resident 22 on March 13, 2024, at 9:44 AM, March 14, 2024, at 1:10 PM revealed that she was in bed and her air mattress was set at 100 pounds.</p> <p>Clinical record review for Resident 260 revealed that the facility admitted her on February 22, 2024, with diagnoses of rhabdomyolysis (damaged tissue releases protein and electrolytes into the blood resulting in potentially permanent disability). An admission assessment dated [DATE], revealed that Resident 260 had an open wound on her right hip measuring 8 centimeters by 2 centimeters with slough (yellow/white dead tissue).</p> <p>On March 12, 2024, staff documented that Resident 260 weighed 159.4 pounds.</p> <p>Resident 260's current physician orders indicated that staff was to place an air mattress to her bed and check inflation and patency every shift.</p> <p>Observation of Resident 260 on March 12, 2024, at 9:53 AM and March 13, 2024, at 9:50 AM revealed that she was in bed and her air mattress was set at 620 pounds.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>This surveyor reviewed the above information with the Nursing Home Administrator and the Director of Nursing on March 14, 2024, at 1:10 PM.</p> <p>Clinical record review for Resident 34 revealed the facility admitted him on May 22, 2023. Review of Resident 34's nursing skin evaluation on August 30, 2023, revealed no skin impairments were observed. The nursing skin evaluation dated September 6, 2023, noted Resident 34's current skin condition changed and a pressure sore was noted on Resident 34's right heel. There was no further assessment, or interventions implemented related to the identified pressure ulcer on Resident 34's heel until September 11, 2023.</p> <p>Nursing documentation dated September 11, 2023, at 10:24 AM, noted a nurse was in to assess Resident 34's heels for potential deep tissue injuries. The nurse assessed Resident 34's left heel measuring 1 by 1.5 centimeters, and the left heel was not blanchable, or open. The nurse assessed Resident 34's right heel measuring 4 by 6 centimeters, and the right heel was open with serosanguinous drainage.</p> <p>The facility did not assess and implement interventions timely to address the pressure area identified on Resident 34's right heel on September 6, 2023.</p> <p>Interview with Employee 9 (assistant director of nursing) on March 15, 2024, at 8:51 AM confirmed these findings. She could provide no further documentation that the facility assessed and implemented interventions to address Resident 34's identified pressure ulcer when identified on September 6, 2023.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p> <p>28 Pa. Code 211.5(f)(ii)(iv)(ix) Medical records</p> <p>28 Pa. Code 211.10(a)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - 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>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 (ROM, movement of the body to maintain a resident's ability) for three of 10 residents reviewed (Residents 69, 66, and 20).</p> <p>Findings include:</p> <p>Interview with Resident 69 on March 12, 2024, at 10:24 AM revealed that he wants to go home. He stated that the staff tell him he needs to be able to walk to be discharged home. Resident 69 indicated that staff do not help him improve his walking.</p> <p>Clinical record review revealed that Resident 69 was discharged from physical therapy on January 5, 2024. Review of the physical therapy discharge summary revealed Resident 69's prognosis was good with consistent staff follow-through. Physical therapy's discharge recommendations included a restorative nursing program to facilitate Resident 69 maintaining his current level of performance and to prevent a decline in his ambulation and transfers.</p> <p>Review of Resident 69's clinical record revealed he was not currently on a restorative nursing program. Review of Resident 69's Documentation Survey Report dated February 2024, documented an intervention for staff to ambulate with Resident 69 to Sycamore Nursing Station with his walker and limited assistance of one staff following with his wheelchair. There was no documentation of the restorative nursing program after February 2, 2024.</p> <p>Interview with Employee 8 (physical therapy assistant, director of therapy) on March 15, 2024, at 10:58 AM confirmed the above findings. Employee 8 could provide no further documentation as to why Resident 69's restorative nursing program was discontinued.</p> <p>Clinical record review for Resident 20 revealed a current care plan for staff to provide ROM (range of motion) to her BLLE (bilateral lower extremities) and BLUE (bilateral upper extremities) twice daily (BID).</p> <p>Review of task documentation for Resident 20 for January and February 2024, revealed that staff did not document completion of the restorative task on the following dates:</p> <p>January 13 and 26, 2024, day shift</p> <p>January 24, 2024, evening shift</p> <p>February 8, 15, and 20, 2024, day shift</p> <p>February 10, 13, and 18, 2024, evening shift</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Wecare at Sycamore Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE  1445 Sycamore Road Montoursville, PA 17754	
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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>Clinical record review for Resident 66 revealed a current care plan for staff to provide a restorative nursing program for her activities daily of living (ADLs, daily resident care and services) with limited assistance for her upper body and extensive assistive for her lower body BID, restorative nursing to ambulate from the foot of her bed to the central bathroom with a front wheel walker with extensive assist of one staff member and the wheelchair to follow BID, AROM (active range of motions) to BLLE BID, and restorative nursing for transfers with extensive assistance of one staff member BID.</p> <p>Review of task documentation for Resident 66 for January, February, and March 2024, revealed that staff did not document completion of the restorative task on the following dates:</p> <p>ADL's-</p> <p>January 5 and 6, 2024</p> <p>February 10, 2024, day shift</p> <p>February 2, 10, and 13, 2024, evening shift</p> <p>March 1 and 8, 2024, day shift</p> <p>Ambulation-</p> <p>January 5 and 6, 2024, day shift</p> <p>February 10, 2024, day shift</p> <p>February 2, 10, and 13, 2024, evening shift</p> <p>March 1 and 8, 2024, day shift</p> <p>AROM-</p> <p>January 5 and 6, 2024, day shift</p> <p>February 10, 2024, day shift</p> <p>February 2, 10, and 13, 2024, evening shift</p> <p>March 1 and 8, 2024, day shift</p> <p>Transfers-</p> <p>January 5 and 6, 2024, day shift</p> <p>February 10, 2024, day shift</p> <p>February 2, 10, and 13, 2024, 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>March 1 and 8, 2024, day shift</p> <p>The surveyor reviewed the above information on March 14, 2024, at 2:30 PM with the Nursing Home Administrator and Director of Nursing.</p> <p>CFR 483.25(c)(2) Mobility</p> <p>Previously cited 3/3/23</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>18229</p> <p>Based on clinical record review, and staff interview it was determined that the facility failed to thoroughly investigate a resident elopement for one of 22 residents sampled (Resident 44)</p> <p>Findings include:</p> <p>Clinical record review revealed the facility admitted Resident 44 on September 1, 2023. Review of Resident 44's care plan initiated on September 2, 2023, revealed that Resident 44 is a high risk for elopement.</p> <p>Nursing documentation dated December 11, 2023, at 10:59 AM revealed Resident 44 followed a staff member off the locked dementia unit. Documentation revealed staff were alerted by the physical therapist that Resident 44 was on another hall. The physical therapist attempted to get Resident 44 back into the dementia unit when Resident 44 grabbed the handrail in the hallway and would not let go. Documentation revealed that it took three staff members to get Resident 44 back to the dementia unit. The documentation further revealed that Resident 44 was having delusions and was noted to be sitting by the locked door to the unit.</p> <p>Interview with the Nursing Home Administrator, Director of Nursing, and Employee 9 (assistant director of nursing) on March 15, 2024, at 8:27 AM, revealed that the facility did not have an investigation into Resident 44's elopement off the locked dementia unit. Further interviews revealed they do not know how Resident 44 got out of the locked dementia unit. The Nursing Home Administrator confirmed the facility could not provide any further documentation that facility staff was interviewed, and educated, or that maintenance checked that the door lock was functioning properly.</p> <p>The facility failed to thoroughly investigate Resident 44's elopement.</p> <p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices</p> <p>Previously cited 03/03/2023.</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident care policies</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>29512</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 two residents reviewed (Resident 8).</p> <p>Findings include:</p> <p>According to the American Association for Respiratory Care proper cleansing of respiratory (nebulizer) equipment reduces infection risk. The longer a dirty nebulizer sits and is allowed to dry, the harder it is to clean thoroughly. Parts of the aerosol drug delivery device should be rinsed and then washed with soap and hot water after each treatment. Once completely dry, store the nebulizer cup and mouthpiece in a zip lock bag.</p> <p>Clinical record review for Resident 8 revealed a current physician order for staff to change their oxygen tubing and bag for their CPAP (continuous positive airway pressure, a device to help treat sleep apnea) tubing weekly on Friday during night shift.</p> <p>Observation of Resident 8's Oxygen concentrator on March 12, 2024, at 9:56 AM and March 13, 2024, at 1:51 PM, revealed that their oxygen tubing was dated March 1, 2024 (12 days prior) and her CPAP mask was lying on top of the bedside stand unbagged. Concurrent interview with Employee 10, licensed practical nurse, during the March 13, 2024, at 1:51 PM observation it was identified that an additional oxygen tubing with the date March 8, 2024, and a clean bag was located inside another bag hanging on Resident 8's bedside stand. Employee 10 confirmed that the March 1, 2024, dated oxygen tubing continued to be in use for Resident 8 at the time of the observation.</p> <p>The surveyor reviewed the above information for Resident 8 during observation and interview with the Director of Nursing and the Nursing Home Administrator on March 14, 2023, at 2:17 PM.</p> <p>28 Pa. Code 211.10 (c)(d) Resident care policies</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>19719</p> <p>Based on clinical record review, resident and staff interview, it was determined that the facility failed to ensure the highest practicable pain management for one of six residents reviewed (Resident 103).</p> <p>Findings include:</p> <p>Clinical record review for Resident 103 revealed that the facility admitted her on January 30, 2024. An admission note dated January 30, 2024, at 3:22 PM, indicated that nursing staff oriented her to the facility and the key locations. There was no documented evidence in the admission note to indicate Resident 103 was experiencing any pain.</p> <p>Review of Resident 103's medication admission orders revealed that she was transferred from the hospital with an order for nursing staff to administer Norco (a combination drug containing acetaminophen and a narcotic pain reliever) 5 mg/325mg (milligrams) one tablet every six hours for moderate to severe pain.</p> <p>Interview on March 12, 2024, at 11:53 AM, with Resident 103 revealed that she had to wait for 59 minutes for a pain pill upon her admission and was in excruciating pain. There was no documented evidence in Resident 103 clinical record to indicate Resident 103 verbalized her pain level to nursing staff upon her admission to the facility.</p> <p>A nursing note dated January 30, 2024, at 10:22 PM, indicated that Resident 103's medications were not available to administer and that she was having severe pain to her left foot. The note indicated that she was medicated with her own pain medication. The note did not indicate Resident 103's level of pain, nor did it indicate how long she was in pain. There was no documented evidence to indicate what medication was administered, by whom, or its effectiveness for Resident 103's pain level.</p> <p>Review of the facility's list of medications available to use in their Cubex (a medication storage system for use when medications are not available by pharmacy) revealed that Norco 5mg/325mg was available for use. There was no documented evidence to indicate that nursing staff used the available Norco in the facility's Cubex system.</p> <p>Interview with Employee 1, registered nurse, on March 14, 2024, at 3:18 PM, revealed that she was the supervisor during the shift of Resident 103's admission. Employee 1 indicated that she misread the Cubex list of available medications and didn't realize that Resident 103's prescribe pain medication of Norco was available to administer.</p> <p>28 Pa. Code 211.12(d)(1)(3)(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 - Some</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 the review of facility documentation, four employee files 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 resident tracheostomy, peg tube, and catheter care.</p> <p>Findings include:</p> <p>A review of the facility documentation revealed that the facility had six residents with urinary catheters (insertion of a tube into the bladder to remove urine), one resident with a tracheostomy (a surgical airway management procedure that consists of making an incision on the anterior aspect of the neck and opening a direct airway through an incision in the trachea), and two residents with peg tubes (medical procedure in which a tube is passed into resident's stomach through the abdominal wall, most commonly to provide a means of feeding).</p> <p>A request for nursing staff competencies for tracheostomy, peg tube, and catheter care revealed the facility was unable to provide any.</p> <p>The findings were reviewed with the Nursing Home Administrator and Director of Nursing on March 14, 2024, at 2:55 PM confirmed the facility could provide no documentation that ensured nurses 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> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>18229</p> <p>Based on staff interviews and review of facility documentation, it was determined that the facility failed to ensure that nurse aides received an annual performance review for three of three nurse aides reviewed (Employees 3, 4, and 5).</p> <p>Findings Include:</p> <p>Review of the facility's list of active nurse aide staff revealed Employee 3 had a hire date of November 15, 2022. Employee 3 should have had an annual performance review by November 15, 2023.</p> <p>Employee 4 had a hire date of November 15, 2022. Employee 4 should have had an annual performance review by November 15, 2023.</p> <p>Employee 5 had a hire date of November 15, 2022. Employee 5 should have had an annual performance review by November 15, 2023.</p> <p>Requests to review Employees 3, 4, and 5's performance reviews revealed no documented evidence that the facility completed the reviews at least once every 12 months.</p> <p>Interview with the Nursing Home Administrator on March 14, 2023, at 10:50 AM confirmed that performance evaluations were not completed.</p> <p>28 Pa. Code 201.19(2) Personnel policies and procedures</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 an individualized person-centered care plan to address dementia and cognitive loss displayed by four of five residents reviewed (Residents 33, 50, 8, and 75).</p> <p>Findings include:</p> <p>Clinical record review for Resident 33 revealed the facility admitted her on October 22, 2023, with diagnosis including Dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life) with other behavior disturbances. A review of Resident 33's admission Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated September 1, 2023, indicated that the facility assessed Resident 33 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 33'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 50 revealed the facility admitted her on October 1, 2020, with diagnosis including Dementia. A review of Resident 50's most recent MDS dated [DATE], indicated that the facility assessed Resident 50 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>The findings were reviewed with the Nursing Home Administrator and Director of Nursing on March 13, 2024, at 2:35 PM. The facility had no further documentation that the facility developed and implemented individualized person-centered care plans to address Resident 33 and 55's dementia and cognitive loss.</p> <p>Clinical record review for Resident 8 revealed that she was admitted to the facility on [DATE]. Resident 8's physician diagnosed her with Dementia on November 2, 2016. An annual MDS completed on January 8, 2024, revealed that the facility indicated that she had Dementia and determined that a care plan for dementia and cognitive loss would be developed.</p> <p>Review of Resident 8's care plan revealed that there was no documentation of an individualized Dementia care plan.</p> <p>Clinical record review for Resident 75 revealed that she was admitted to the facility on [DATE], with diagnosis including dementia.</p> <p>Review of Resident 75's most recent comprehensive MDS dated [DATE], revealed that the facility determined that a care plan for cognitive loss and dementia would be developed.</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>Review of Resident 75's current care plan revealed that there was no evidence of an individualized dementia care plan.</p> <p>The surveyor reviewed the above information regarding Resident 75, during an interview on March 15, 2024, at 8:46 AM with the Nursing Home Administrator.</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>19719</p> <p>Based on clinical record review, review of select policies and procedures, and resident and staff interview, it was determined that the facility failed to ensure accurate acquiring and dispensing of medications for one of 22 residents reviewed (Resident 103).</p> <p>Findings include:</p> <p>The policy entitled Remedi, Pharmacy Contact Info, last reviewed on December 4, 2023, indicates that for any new admissions, facility staff must call the pharmacy for any new admissions orders. The pharmacy will not automatically send medications from a facsimile.</p> <p>The policy entitled Medications brought to the facility by the resident last reviewed on December 4, 2023, indicates that if a medication is not available and have been determined to be essential to the resident's life, the Director of Nursing and nursing staff along with the support of the attending physician to ensure that the medication has been ordered by the resident's physician.</p> <p>Review of Resident 103's medication admission orders revealed that she was transferred from the hospital with an order for nursing staff to administer Norco (a combination drug containing acetaminophen and a narcotic pain reliever) 5 mg/325mg (milligrams) one tablet every six hours for moderate to severe pain. A nursing note dated January 30, 2024, at 3:22 PM, indicated that Resident 103 was admitted and oriented to the facility.</p> <p>Interview on March 12, 2024, at 11:53 AM, with Resident 103 revealed that none of her pills were here when she was admitted . Resident 103 also indicated that she had to wait for one of her pain pills because the facility didn't have it on hand, and that she took one of her own pills that she brought to the facility.</p> <p>A nursing note dated January 30, 2024, at 10:22 PM, indicated that Resident 103's medications were not available to administer and that she was having severe pain to her left foot. The note indicated that she was medicated with her own pain medication. There was no documented evidence to indicate that Resident 103's physician was made aware that she brought her own medication, nor if nursing staff ensured it was a medication ordered by her physician.</p> <p>Review of Resident 103's Medication Administration Record (MAR, a form used to document the administration of medications) dated January 2024, revealed that her physician ordered Allegra (for allergies), Combigan (treats eye diseases), and Mirapex (treats restless leg syndrome) were not administered for the 8:00 PM dose. There was no documented evidence in Resident 103's clinical record to indicate if nursing staff called the pharmacy as required or why the medications were not administered.</p> <p>Interview with the Administrator and Director of Nursing on March 14, 2024, at 2:00 PM, confirmed the above findings for Resident 103, and could not provide further documented evidence to indicate why her medications were not administered as ordered.</p> <p>28 Pa. Code 211.9 (a)(1)(d)(e)(4)(k) Pharmacy services</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>18229</p> <p>Based on clinical record review, and staff interview, it was determined that the facility failed to ensure that the resident's attending physician addressed and responded appropriately to pharmacy recommendations for four of six residents reviewed (Resident 64, 33, 50, and 75) and failed to ensure that the consulting pharmacy identified potential appropriateness for psychoactive medications for one of six residents reviewed (Resident 64).</p> <p>Findings include:</p> <p>Review of Resident 64's clinical record revealed a physician order dated September 22, 2022, for nursing staff to administer Zoloft (used to treat depression) 150 mg (milligrams) every day for schizoaffective disorder (a combination of symptoms of schizophrenia and bipolar disorder).</p> <p>A consultant pharmacy review dated September 1, 2023, indicated that Resident 64 has been on the current dose of Zoloft since September 2022 and that her physician review the current dose and should consider a gradual dose reduction. There was no documented evidence that Resident 64's physician addressed the consultant pharmacist's recommendation. Resident 64 continued to get the 150 mg of Zoloft for an additional two months before a gradual dose reduction was attempted.</p> <p>Review of Resident 64's clinical record revealed a nursing progress noted dated November 13, 2023, that indicated her attending physician was going to write an order for nursing staff to decrease her dose of Seroquel (a medication that treats mental disorders) to 12.5 mg in the morning and 25 mg in the evening. Review of the order dated November 13, 2023, indicated the above changes.</p> <p>Review of Resident 64's Medication Administration Record (MAR, a form used to document the administration of medications) dated November 2023 revealed that in addition to the above orders changes for Resident 64's Seroquel, the nurse transcribing the order also entered an order for an additional 50 mg of Seroquel to be given in the morning. There was no documented evidence to indicate that Resident 64's attending physician authorized the extra 50 mg of Seroquel.</p> <p>A consultant pharmacy review was conducted on November 17, 2023, with no recommendations for Resident 64's attending physician. The consultant pharmacist did not identify that Resident 64 was receiving an extra 50 mg of Seroquel that her physician did not order.</p> <p>Interview with the Director of Nursing on March 15, 2024, at 9:32AM confirmed the above findings for Resident 64.</p> <p>A consultant pharmacy review dated December 19, 2023, requested Resident 33's physician consider ordering a Lipid Panel (a blood test that can measure the amount of cholesterol in your blood), CBC (complete blood count, is a blood test used to look at overall health), BMP (basic metabolic panel, a test that measures eight different substances in your blood), and Vitamin D level. There was no documented evidence that Resident 33's physician addressed the consultant pharmacist's recommendation from December 19, 2023.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Wecare at Sycamore Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE  1445 Sycamore Road Montoursville, PA 17754	
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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A consultant pharmacy review dated January 22, 2024, indicated Resident 33 has an order for Seroquel with an indication of dementia. The consultant pharmacist requested Resident 33's physician change the indication for Resident 33's Seroquel to depression. There was no documented evidence that Resident 33's physician addressed the consultant pharmacist recommendations from January 22, 2024.</p> <p>A consultant pharmacy review dated December 19, 2023, noted Resident 50 has four psychotropic medication orders for at least three to 12 months that are now potentially due for a gradual dose reduction based on CMS guidelines. The consultant pharmacist requested Resident 50's physician evaluate if Resident 50 is a candidate for gradual dose reduction and consider a reduction in the total daily dose of any of the four psychotropic medication orders. There was no documented evidence that Resident 50's physician addressed the consultant pharmacist's recommendation from December 19, 2023.</p> <p>Interview with Employee 9 (assistant director of nursing) on March 14, 2024, at 1:02 PM confirmed the above findings for Residents 33 and 50.</p> <p>A consultant pharmacy review dated November 22, 2023, noted that Resident 75 had an order for Olanzapine (a medication used to treat schizophrenia, bipolar disorder, and depression). The consulting pharmacist requested that the physician change the indication for use to depression. Resident 75's physician addressed the recommendation on November 28, 2023. He declined to change the indication for use marked the box that indicated to continue the zyprexa order with the current indication and that he was aware that olanzapine is not FDA approved for agitation/hallucination but the benefits to the resident outweighs any potential adverse side effect risks. He also documented under the physician reponse area that the resident is on hospice with metastatic cancer. The physician failed to provide an appropriate indication for use of the medication Olanzapine for Resident 75.</p> <p>Interview with Employee 9, on March 15, 2024, at 11:00 AM confirmed the above noted finding related to Resident 75.</p> <p>28 Pa. Code 211.9 (d)(k) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>19719</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medications for three of five residents reviewed (Residents 2, 8, and 64).</p> <p>Findings include:</p> <p>Clinical record review for Resident 8 revealed current physician orders for Seroquel (for bipolar disorder) 75 milligrams (mg) by mouth (PO) at bedtime (HS), Seroquel 50 mg PO twice daily (BID), Depakote sprinkles (for bipolar disorder) 125 mg two capsules PO daily (QD) and one capsule PO BID, and Duloxetine (for Depression) 60 mg PO QD.</p> <p>Resident 8's physician ordered the every shift staff to monitor her for dry mouth, constipation blurred vision, disorientation/confusion, difficulty urinating, hypotension (low blood pressure), dark urine, yellow skin, nausea and/or vomiting, lethargy drooling, tremors, disturbed gait, increased agitation, restlessness, and/or involuntary movement of the mouth or tongue. Staff were to document Y if monitored and none of the above were observed or N if monitored and any of the above was observed, select chart code other/see nurses notes and progress note findings related to bipolar disorder and Depression.</p> <p>Review of Resident 8's January, February, and March 2024 MAR (medication administration record, a form to document medication administration) and clinical record revealed that there was no documentation that staff were monitoring Resident 8 for the above noted physician ordered signs and symptoms or behaviors.</p> <p>The surveyor reviewed the above for Resident 8 during an interview with the Nursing Home Administrator on March 15, 2024, at 8:58 AM.</p> <p>Review of Resident 2's clinical record revealed a current physician order for nursing staff to administer Ativan (helps with anxiety) .5 mg three times a day for anxiety, Remeron (an anti-depressant) 45 mg at bedtime for depression, and Risperdal (used to treat mental disorders) 2mg three times a day for psychosis.</p> <p>A physician order dated December 3, 2023, indicated that nursing staff were to monitor Resident 2's behaviors such as crying, wringing of her hands, outbursts, and physical aggression. Review of Resident 2's MAR dated March 2024 revealed that there was no documented evidence that the facility was tracking Resident 2's behaviors to determine what behavior she was exhibiting, how many episodes, or what interventions nursing staff were using to help alleviate the behavior.</p> <p>Review of Resident 64's clinical record revealed a current physician order for nursing staff to administer Seroquel (treats depression) 12.5 mg every morning and 25 mg every evening, and Zoloft (treats depression) 100 mg every day, both to treat her depression.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A physician order dated December 28, 2023, indicated that nursing staff were to monitor Resident 64's behaviors such as agitation, restlessness, anger, fear, hallucinations, sadness, crying, and fatigue. Review of Resident 64's MAR dated March 2024 revealed that there was no documented evidence that the facility was tracking Resident 64's behaviors to determine what behavior she was exhibiting, how many episodes, or what interventions nursing staff were using to help alleviate the behavior.</p> <p>The above findings for Resident 2 and 64 were reviewed with the Administrator and Director of Nursing on March 14, 2023, at 2:00 PM.</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy services</p> <p>28 Pa. Code 211.10(a) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>36798</p> <p>Based on observation and staff interviews, it was determined that the facility failed to prevent the potential spread of infection to one of five residents reviewed for infection control. (Residents 10).</p> <p>Findings include:</p> <p>Observation of Resident 10's door to her room revealed a sign indicating that she was on enhanced barrier precautions. (EBPs, precautions used to prevent the spread of multi-drug resistant organisms). The sign indicated to use gloves and to wear a gown with device care, and listed one example of device care as a tracheostomy ( An opening in the front of the neck with a tube inserted directly into the airway that allows a person to breath).</p> <p>Observation of Resident 10's tracheostomy care on March 14, 2024, at 8:20 AM with Employee 2, LPN (Licensed Practical Nurse), revealed that she performed the care without putting a gown on.</p> <p>Interview with the Director of Nursing on March 14, 2024, at 2:51 PM revealed that Employee 2 should have worn a gown to perform Resident 10's tracheostomy care.</p> <p>The facility failed to prevent the potential spread of a multi-drug resistant infection to Resident 10.</p> <p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention &amp; Control</p> <p>Previously cited 03/03/2023</p> <p>28 Pa. Code 201.18 (d) Management</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>29512</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to perform an assessment for possible entrapment after installation of enabler bars and/or side rails for two of two residents reviewed (Residents 22 and 66).</p> <p>Findings include:</p> <p>Observation of Resident 22 on March 13, 2024, at 9:41 AM revealed that she was in bed sleeping. There was an enabler bar on the left side of her bed.</p> <p>Clinical record review for Resident 22 revealed that she requested the use of enabler(s) on November 10, 2023.</p> <p>There is no documentation indicating that the facility assessed Resident 22's bed to ensure that that the enabler bar placed on Resident 22's bed was compatible with the mattress and/or bed frame utilized and there was no documentation that the facility completed an assessment to ensure that there was not the potential for entrapment while utilizing an enabler bar on Resident 22's bed.</p> <p>Observation of Resident 66 on March 12, 2024, at 11:14 AM revealed that there were bilateral enabler bars on her bed.</p> <p>Clinical record review for Resident 66 revealed that the facility completed an assessment for the use of enabler bars to promote independence on October 5, 2023.</p> <p>There is no documentation indicating that the facility assessed Resident 66's bed to ensure that that the enabler bars placed on Resident 66's bed was compatible with the mattress and/or bed frame utilized and there was no documentation that the facility completed an assessment to ensure that there was not the potential for entrapment while utilizing enabler bars on Resident 66's bed.</p> <p>The surveyor reviewed the above information during an interview with the Nursing Home Administrator on March 14, 2024, at 1:25 PM.</p> <p>28 Pa Code 211.12(d)(3)(5) Nursing services</p>