

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Williamsport South Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Leader Drive Williamsport, PA 17701	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>29512</p> <p>Based on review of select facility policies, facility documentation, clinical record review, and staff interview, it was determined that the facility failed to ensure that residents were free from neglect for one of five residents reviewed resulting in actual harm (Resident 1, East Hall Nursing Unit).</p> <p>This deficiency is cited as past noncompliance.</p> <p>Findings include:</p> <p>The current facility policy entitled Abuse, revealed that they identified neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility was aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide them to the resident, that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety, resulted in or could have resulted in physical harm, pain, mental anguish, or emotional distress. A covered individual is anyone who is an owner, operator, employee, manager, agent, or contractor of the facility. Willful is defined in the definition of abuse and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. It is the facility policy that each resident will be free from abuse. Residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection.</p> <p>Clinical record review for Resident 1 revealed that on April 14, 2024, at 7:05 PM Employee 1, licensed practical nurse (LPN), documented a concern (was broken) with the facility's bladder scanner when she attempted to bladder scan Resident 1 per his physician's order to determine the amount of urine in the bladder if his (urine) output was less than 250 cubic centimeters (cc). Employee 1 documented Resident 1's urine output for the evening shift was 200 cc.</p> <p>At 8:30 PM, Employee 1 documented that she held Resident 1's physician ordered Lantus insulin 10 units. Resident 1's blood sugar was 104 mg/dl (milligrams/deciliter) at the time the insulin was held. Review of Resident 1's physician orders revealed no parameters (i.e., hold if less than 120 mg/dl) to hold Resident 1's insulin.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's April 2024 MAR (medication administration record, a form to document medication administration) revealed that Employee 1, LPN, documented that Resident 1 refused his Oxycodone (narcotic) at 12:00 PM and his Fentanyl (narcotic) patch at 12:21 PM. Employee 1 documented that Resident 1 refused his physician ordered Eliquis (blood thinner) and Ensure (dietary supplement) at 5:00 PM, his Oxycodone at 6:00 PM and 10:00 PM, his Lidocaine (pain medication) and Milk of Magnesia (for constipation) at 8:00 PM.</p> <p>There was no other documentation on April 14, 2024, during the day or evening shift that indicated concerns with the health and welfare of Resident 1.</p> <p>On April 15, 2024, at 12:52 AM Employee 3, registered nurse (RN), documented this nurse was alerted to resident (Resident 1) change in condition reported from prior shift per LPN. This nurse assessed for profound AMS (altered mental status), right sided facial droop, decreased mobility, and weakened grasp in RUE (right upper extremity). Febrile 100.9 (degrees Fahrenheit), bradycardic (slow pulse) at 24 BPM (beats per minute), minimally responsive to verbal and tactile stimuli, inappropriate verbal response when able. BP (blood pressure)/HR (heart rate) labile (unstable). This nurse immediately summoned staff support, code blue on standby (Resident 1 was a full code), 911 dispatched. (Medical Director) on-call service physician assistant-certified: made aware and in agreement with transfer. New orders received: transfer to ER (emergency room) for evaluation and treatment related to AMS, rule out CVA (cerebral vascular accident, stroke), bradycardia (slow pulse), fever. Transferred via EMS (emergency medical services). Paperwork and POLST (code status) surrendered. Will follow up for outcome of transfer.</p> <p>Review of Resident 1's hospital documentation dated April 15, 2024, at 1:09 AM revealed that the ambulance (EMS) called a stroke alert enroute to the hospital as right sided weakness and slurred speech was noted. In the ER, the physician noted a Glasgow Coma Scale (to determine potential brain injury) of 12 (moderate brain injury) and a National Institute of Scale's Stroke Score of 18 (moderate/severe stroke) with bilateral (both) upper and lower extremity (arm/leg) drift, right sided facial droop, dysarthria (weak muscles causing difficulty speaking), and aphasia (loss of ability to understand and/or express speech caused by brain injury), tachycardia (fast pulse) of 100 BPM. Neurology was consulted who recommended admission for an MRI (magnetic resonance imaging) and further stroke workup.</p> <p>Employee 4's, RN, witness statement dated April 17, 2024, revealed that when she arrived tonight at 10:45 PM, Employee 5, RN, informed her that on her previously worked shift (April 14, 2024, 3-11 PM) Employee 1 did not report to her that Resident 1 was having health issues on the entire shift. This was also reported to Employee 4 by Employee 6, LPN. Per Employee 6, Employee 1 informed the 11-7 AM LPNs of the issue with Resident 1 and instructed them to call their supervisor, Employee 3, to have (Resident 1) assessed. Resident 1 was transferred to the hospital and admitted .</p> <p>Review of Employee 5's witness statement dated April 22, 2024, revealed he was discussing pertinent information regarding recent admissions to the hospital with and LPN (Employee 1) that works 3-11 PM frequently on East Hall (Resident 1's unit). I asked when she first noted a change in (Resident 1's) condition. Her response was that she passed the information to oncoming staff/RN. Employee 5 asked why she didn't give this information to the RN during her shift? (Employee 1's) response was that because she doesn't speak to that RN. Employee 5 told Employee 1 that we have to work together regardless. (Employee 1) laughed and said NO.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Director of Nursing (DON) on April 19, 2024, at 9:17 AM revealed that he was unaware of the concern identified by Employee 4 until April 22, 2024, as Employee 4 had slipped her witness statement under his door. The DON indicated once notified he initiated a facility investigation immediately.</p> <p>Interview on May 2, 2024, at 9:17 AM and on May 2, 2024, 3:30 PM with the Nursing Home Administrator indicated that the facility substantiated their investigation and founded that Employee 1 neglected Resident 1 while in her care. The DON indicated that Employee 1 was terminated.</p> <p>Past non-compliance was determined that the facility failed to ensure a safe environment that was free from neglect from April 14, 2024, through April 26, 2024.</p> <p>28 Pa. Code 201.18(b)(2)(e)(1) Management</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		