

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 05/22/2024
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 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>20725</p> <p>Based on review of select facility policies and procedures, review of employee personnel records, and staff interview, it was determined that the facility failed to thoroughly investigate and report to the required agencies an allegation of resident mental abuse for one of five residents reviewed (Resident CR1).</p> <p>Findings include:</p> <p>The CMS State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care, revised February 3, 2023, defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled by technology. Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Mental abuse includes abuse that is facilitated or enabled through the use of technology, such as smartphones and other personal electronic devices. This would include keeping and/or distributing demeaning or humiliating photographs and recordings through social media or multimedia messaging. Depending on what was photographed or recorded, physical and/or sexual abuse may also be identified.</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>The facility policy entitled, Abuse Policy - PA, published December 4, 2023, defined mental abuse as the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. It is the policy of the facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation, and misappropriation of property) are promptly and thoroughly investigated. The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. The investigation will include: who was involved, involved staff and witness statements of events, and environmental considerations. All staff must cooperate during the investigation to assure the resident is fully protected. The results of the investigation will be recorded and attached to the report. All reports of suspected crime and/or alleged sexual abuse must be immediately reported to local law enforcement to be investigated. Facility staff will fully cooperate with the local law enforcement designee. The follow-up investigative notes will be submitted online within five working days of the initial report. Procedures must be in place to provide the resident with a safe, protected environment during the investigation which included notification of law enforcement and/or state agency as indicated. Complaints about a nursing assistant must be reported to the state specific agency for nursing assistants. If an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or within 24 hours) report to the State agency. The facility must submit reports that are accurate, to the best of its knowledge at the time of submission of the report.</p> <p>The facility policy did not include that the inappropriate use of technology, taking resident pictures, or taking resident videos, are examples of mental abuse as stipulated in the State Operations Manual.</p> <p>Review of Employee 1's (nurse aide) personnel file revealed an, Employee Education/Counseling Form, dated May 7, 2024, that described an incident as, It was brought to the facility's attention of (Employee 1) having used her electronic device (phone). The facility noted a review of the electronic devices portion of the handbook. The only handbook reference highlighted noted, The use of iPods, air pods, or any recording and/or video device inside the Facility is prohibited. Failure to adhere to this policy may result in discipline up to and including termination. The Nursing Home Administrator and Employee 1 signed the document on May 9, 2024.</p> <p>There was no other information regarding for what purpose Employee 1 used her phone (e.g., record the inside of the facility, take pictures of residents, record other employees, etc.).</p> <p>A witness statement from Employee 1 dated May 7, 2024, noted, I have never taken a photo or video of a resident. There was no other information provided in the statement.</p> <p>Interview with the Nursing Home Administrator (NHA) on May 22, 2024, at 12:05 PM indicated that Employee 1's education was necessary because the NHA received an email dated May 3, 2024, at 8:35 AM of a picture of a toilet.</p> <p>The email did not include Employee 1's name or reference to any facility resident.</p> <p>(continued on next page)</p>		

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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>When the surveyor requested information from the facility regarding how a picture of a toilet indicated Employee 1 required education pertaining to phone use, the NHA provided a statement from Employee 2 (medical records) dated May 3, 2024, that noted, I was told by a CNA (nurse aide) that (Employee 1) was taking pictures and videos of her residents and sent them to people including her boyfriend .(the boyfriend) called several times to the facility but was hung up on because (Employee 1) told (Employee 3, licensed practical nurse/unit manager) to take the calls and that her boyfriend was just trying to get her fired. (The boyfriend) called a lot, myself and (Employee 4, social services) and I'm not sure who else heard (Employee 3) say, that (the boyfriend) is crazy and won't stop calling etc. (This was before the CNA came to me on Fri 5/3 (Friday May 3, 2024) and said (Employee 3) never took the calls for (the boyfriend) to report what (Employee 1) was doing) because (Employee 1) tried to intercept the situation by telling (Employee 3) this was just boyfriend drama. This CNA did not want involved out of fear of (Employee 1) retaliating on her.</p> <p>Interview with the NHA on May 22, 2024, at 12:05 PM confirmed that the facility did not attempt to obtain a statement from Employee 1's boyfriend, Employee 3, or Employee 4, regarding the reported concern. The facility did not notify the Department or other agencies (Area Agency on Aging or law enforcement) regarding the allegation of staff taking photos or videos of a resident inappropriately.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide bathing assistance for a dependent resident for one of five residents reviewed (Resident CR1).</p> <p>Findings include:</p> <p>Closed clinical record review for Resident CR1 revealed that she resided in the facility from [DATE], to May 10, 2024.</p> <p>Review of an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated April 3, 2024, revealed that staff assessed that Resident CR1 was dependent upon staff to shower or bathe.</p> <p>Review of the Documentation Survey Report (electronic documentation by nurse aides for the completion of tasks related to activities of daily living) dated April 2024, for Resident CR1 revealed that nurse aides were to complete bathing via a bed bath on Tuesdays and Saturdays. Staff documented that Resident CR1 required the physical help of staff or was completely dependent upon the physical performance of the task by staff for bathing. The report revealed that staff failed to document the completion of a bed bath for Resident CR1 on the following dates:</p> <p>Saturday, April 13, 2024</p> <p>Tuesday, April 16, 2024</p> <p>Saturday, April 27, 2024</p> <p>The surveyor reviewed the above findings for Resident CR1 during an interview with the Nursing Home Administrator on May 23, 2024, at 10:45 AM.</p> <p>483.24(a)(2) ADL Care Provided for Dependent Residents</p> <p>Previously cited deficiency 2/16/24</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that a physician supervised the care of one of five residents reviewed (Resident CR1).</p> <p>Findings include:</p> <p>Closed clinical record review for Resident CR1 revealed that she resided in the facility from [DATE], to May 10, 2024. Diagnoses for Resident CR1 did not indicate a history of cancer or radiation treatments.</p> <p>A verbal physician order dated April 10, 2024, instructed staff to administer Temozolomide (medication used to treat certain types of brain cancer) 140 mg (milligrams) by mouth one time a day for, give med for duration of radiation NPO (nothing by mouth) for 90 min (minutes) prior to administration.</p> <p>There was no appropriate diagnosis included with the Temozolomide medication order as the resident did not have cancer and was not prescribed radiation therapy.</p> <p>Employee 5 (certified registered nurse practitioner, CRNP) electronically signed the order on April 15, 2024, for nursing staff to implement the medication. There was no indication that Employee 5 identified that there was no appropriate diagnosis for its use.</p> <p>Employee 6 (CRNP) documented progress notes that stipulated that Resident CR1's medication list was reviewed and/or reconciled during visits on the following dates and times:</p> <p>April 16, 2024, at 11:24 PM</p> <p>April 19, 2024, at 2:58 PM</p> <p>April 21, 2024, at 6:44 PM</p> <p>April 23, 2024, at 1:32 PM</p> <p>April 26, 2024, at 4:37 PM</p> <p>May 1, 2024, at 10:35 PM</p> <p>May 6, 2024, at 6:27 PM</p> <p>The practitioner did not identify that Temozolomide was included in Resident CR1's medication profile without an appropriate diagnosis or indication for its use during any of those visits.</p> <p>(continued on next page)</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nursing staff discontinued the April 10, 2024, Temozolomide order on April 22, 2024, but entered a new verbal order on April 22, 2024, with the same administration parameter to administer the medication for the duration of radiation therapy. Employee 7 (Doctor of Medicine, MD) electronically signed the order on April 24, 2024.</p> <p>The practitioner did not identify that Temozolomide was included in Resident CR1's medication profile without an appropriate diagnosis or indication for its use.</p> <p>Interview with the Nursing Home Administrator, the Director of Nursing, and Employee 2 (medical records) on May 22, 2024, at 1:05 PM confirmed the above findings regarding Resident CR1's Temozolomide medication.</p> <p>The facility was unable to provide evidence that physician practitioners conducted a medical evaluation of a resident before ordering a new medication.</p> <p>28 Pa. Code 211.2(d)(3)(8)(9)(10) Medical director</p> <p>28 Pa. Code 211.12(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 - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725</p> <p>Based on closed clinical record review and staff interview, it was determined that the facility failed to ensure that the consultant pharmacist identified a potential medication irregularity for physician review for one of five residents reviewed (Resident CR1).</p> <p>Findings include:</p> <p>Closed clinical record review for Resident CR1 revealed that she resided in the facility from [DATE], to May 10, 2024. Diagnoses for Resident CR1 did not indicate a history of cancer or radiation treatments.</p> <p>A verbal physician order dated April 10, 2024, instructed staff to administer Temozolomide (medication used to treat certain types of brain cancer) 140 mg (milligrams) by mouth one time a day for, give med for duration of radiation NPO (nothing by mouth) for 90 min (minutes) prior to administration.</p> <p>There was no appropriate diagnosis included with the Temozolomide medication order as the resident did not have cancer and was not prescribed radiation therapy.</p> <p>A Pharmacy Monthly Medication Review dated April 16, 2024, at 10:03 AM indicated that Resident CR1 was reviewed by the consultant pharmacist and to, See report for recommendation.</p> <p>Interview with the Nursing Home Administrator, the Director of Nursing, and Employee 2 (medical records) on May 22, 2024, at 1:05 PM confirmed that the consultant pharmacist did not provide a written report to the attending physician and the Director of Nursing identifying the potential medication irregularity that Resident CR1 was prescribed a medication used for cancer with no appropriate cancer diagnosis and with parameters pertinent to radiation therapy when Resident CR1 did not receive radiation treatments.</p> <p>483.45(c)(4) Drug Regimen Review</p> <p>Previously cited deficiency 2/16/24</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725</p> <p>Based on closed clinical record review and staff interview, it was determined that the facility failed to ensure each resident's medication regimen was free from unnecessary medications for one of five residents reviewed (Resident CR1).</p> <p>Findings include:</p> <p>Closed clinical record review for Resident CR1 revealed that she resided in the facility from [DATE], to May 10, 2024. Diagnoses for Resident CR1 did not indicate a history of cancer or radiation treatments.</p> <p>A verbal physician order dated April 10, 2024, instructed staff to administer Temozolomide (medication is used to treat certain types of brain cancer) 140 mg (milligrams) by mouth one time a day, give med for duration of radiation NPO (nothing by mouth) for 90 min (minutes) prior to administration.</p> <p>There was no appropriate diagnosis included with the Temozolomide medication order as the resident did not have cancer and was not prescribed radiation therapy.</p> <p>Employee 5 (certified registered nurse practitioner, CRNP) electronically signed the order on April 15, 2024, for nursing staff to implement the medication.</p> <p>Nursing staff discontinued the April 10, 2024, Temozolomide order on April 22, 2024, but entered a new verbal order on April 22, 2024, with the same administration parameter to administer the medication for the duration of radiation therapy. Employee 7 (Doctor of Medicine, MD) electronically signed the order on April 24, 2024.</p> <p>The practitioner did not identify that Temozolomide was included in Resident CR1's medication profile without an appropriate diagnosis or indication for its use.</p> <p>Interview with the Nursing Home Administrator, the Director of Nursing, and Employee 2 (medical records) on May 22, 2024, at 1:05 PM confirmed the above findings regarding Resident CR1's Temozolomide medication.</p> <p>The facility implemented Temozolomide in Resident CR1's medication regimen without adequate indications for its use.</p> <p>28 Pa. Code 211.9(k) Pharmacy services</p> <p>28 Pa. Code 211.2(d)(3)(9) Medical director</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		