STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395400	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Susquehanna Health and Wellness Center	745 Old Chickies Hill Road Columbia, PA 17512

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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35913 Based upon review of facility policy and procedure, clinical record review and review of documentation provided by the facility, it was determined the facility failed to honor residents' rights relating to ambulation equipment and medication for two of twenty-nine residents reviewed (Resident 100 and Resident 145). Findings include: Review of facility policy and procedure titled Administering Medications, revised [DATE], revealed Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include honoring resident choices and preferences, consistent with his or her care plan. Review of Resident 100's clinical record revealed Resident 100 sustained a fall consisting of slipping out of bed on February 16, 2024. Review of documentation provided by the facility revealed that Resident 100's walker and wheelchair would be kept out of Resident 100's sight and reach to prevent resident from attempting to get out of bed and walk unassisted. Review of Resident 100's current plan of care revealed an intervention for falls stating wheelchair and walker to be kept out of sight of resident. Resident will not ambulate without equipment. Interview with the Assistant Director of Nursing on [DATE], at 11:15 a.m. revealed Resident 100 was unable to ambulate without either a wheelchair or walker. The removal of the wheelchair and walker was an attempt to keep resident from ambulating after being placed in bed. The interview further revealed that if Resident 100 wanted to ambulate then the resident would have to ring the call bell, which Resident 100 was continually educated on and failed to do. Removal of Resident 100's wheelchair and walker from reach and/or sight prohibited Resident 100 from ambulating as desired. Review of Resident 145's diagnosis list revealed a diagnosis of dementia (irreversible progressive degenerative disease of the brain resulting in loss of reality contact and functioning ability. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 145's clinical record revealed Resident 145 was admitted to the facility on [DATE], and expired on [DATE]. Review of Resident 145's clinical progress notes dated [DATE], revealed Resident refused all am medications this morning x3. First attempt whole, she spit them out, second attempt crushed, she refused, 3rd attempt put in ice cream, refused to eat, refused breakfast, will not eat anything, resident states 'I just want to sleep'. The facility failed to honor resident 145's refusal of medications by forcing three attempts to take the medication, including hiding the medication in ice cream. The above information was conveyed to the Nursing Home Administrator and Assistant Director of Nursing on [DATE], at 11:30 a.m. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35913 Based upon observation, it was determined the facility failed to provide a clean, comfortable, and homelike environment for two nursing units of four observed (two nursing units in the B Wing of the facility). Findings include: Observation of both B Wing nursing units on all days of the survey revealed carpeting that was worn, dirty and stained in multiple areas and odorous. Interview with the Nursing Home Administrator on March 29, 2024, at 11:00 a.m. revealed that a quote had been acquired to replace the carpeting, however no replacement had been completed in the past year. The facility failed to provide a clean, comfortable, and homelike environment on two of four nursing units observed. 28 Pa. Code 201.18(a)(b)(3) Management

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 35913 Based on a review of the facility's policy, clinical records review, facility documentation review, and staff interviews, it was determined that the facility failed to investigate bruises of unknown origin and thoroughly investigate allegations of rape for two of the 30 residents reviewed (Resident 58 and 100). Findings include: Review of the facility's policy titled Abuse Investigation and Reporting, revised in July 2017, revealed that all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries on unknown cause shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. Review of Resident 58's diagnosis list includes PTSD (Post Traumatic Stress Syndrome) and Anxiety disorder. Review of the nursing progress notes dated March 17, 2024, at 6:55 a.m., revealed, two staff heard the resident talking on the phone and reported that she/he cannot breathe and that she was getting raped. The resident demanded to be picked up by the ambulance because she was getting abused. Review of the facility investigation and statement of Employee E8 revealed that her/him and another staff, while caring for another resident in the room heard Resident 58 talking to a man on the phone trying to tell her/his location but unable to remember. The resident asked the staff to tell 911 her/his location, the person on the other line asked if the resident was in danger, and the staff responded that the resident was safe but confused. The resident yelled at the staff, asked what they were doing in the room, and informed the person on the phone that she was being raped and that she could not breathe. The incident was reported to the supervisor. Review of the facility investigation and statement of Employee E9 revealed that while she/he and Employee E8 were caring for another resident in the room, Resident 58 was on the phone and asked Employee E8 to tell the 911 dispatcher the location of the facility. Employee E8 informed the 911 dispatcher of the name of the facility and that the resident was safe and was having confusion, then the resident said that she had been raped and can't breathe. Employee E8 reported the incident to the supervisor. Review of the physician's note dated March 18, 2024, revealed the resident was seen and evaluated for allegation of rape. The resident reported that the incident occurred on the morning of March 17th at approximately 7:00 a.m. The resident reported that a female nurse wearing a jumpsuit and mask, allegedly touched the resident's private area and inserted objects. The physician's notes revealed that the resident did not have physical signs of altercation but presented with marked confusion, erratic behavior, and confusion for the last few days. A urine test was ordered. Review of the nursing progress notes dated March 18, 2024, at 2:21 p.m., revealed a skin assessment completed on Resident 58, no abnormal marks, no bruises, no skin opening, and no genitalia intact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the facility documentation revealed that aside from the two employees who overheard the phone conversation with the 911 dispatcher in the early morning of March 17, 2024, no other staff that worked or could have possibly had contact with the resident was interviewed despite Employee E9's statement that the resident told the 911 dispatcher that she had been raped. The above information was conveyed to the Nursing Home Administrator on March 29, 2024, at 1:00 p.m. The facility failed to ensure Resident 58's allegation of rape was thoroughly investigated. Review of Resident 100's clinical progress notes dated October 22, 2023, revealed On arrival to resident room resident, she was found lying on left side next to clothing cabinet. Call light was not on. Resident was wearing a blouse, slacks and shoes. She was continent of bowel and bladder. She was last seen by staff within the hour of fall. No clutter was found on the floor. Roommates folded fall mat was placed off to the side. Review of Resident 100's clinical progress notes dated October 29, 2023, revealed Noted bruises right upper flank 8 cm [centimeters] x 2 cm yellow/green and right lateral breast 1.3 cm x 5 cm purple. Denies pain/discomfort. +ROM [range of motion] WNL [within normal limits]. No documentation was provided to indicate that Resident 100's bruises were investigated to rule out abuse. Interview with the Assistant Director of Nursing on March 29, 2023, at 11:30 a.m. revealed the facility assumed the bruises were from the fall that occurred on October 22, 2023. Both bruises were noted on Resident 100's right side. Documentation provided by facility and clinical progress notes indicate Resident 100 fell on the left side, not the right side. The facility failed to investigate bruises of an unknown origin to rule out abuse. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on review of clinical record and facility documentation and staff interviews, it was determined that the facility failed to follow care plan interventions to prevent falls for one of seven residents, resulting in actual harm to Resident 106, who fell , requiring emergency care and three staples to treat a laceration to the head. The facility also failed to develop a comprehensive care plan regareding aggressive behaviors for one of 30 residents reviewed (Resident 39). Findings include: Review of Resident 106's clinical record revealed diagnoses including Dementia (loss of cognitive functioning that interferes with daily life and activities), Down's syndrome (genetic disorder associated with physical growth delays, characteristic facial features and mild to moderate developmental and intellectual disability), cognitive communication deficit, unspecified Psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality), and generalized Muscle Weakness. Review of Resident 106's Annual Minimum Data Set (MDS - periodic assessment of resident care needs) dated November 2, 2023, revealed the resident scored a BIMS (Brief Interview for Mental Status) of 02, indicating severe cognitive impairment. Further review of the resident's MDS revealed under Section J (Health Conditions) the resident had two falls with no injury and one fall with injury within the lookback period. Review of Resident 106's progress notes revealed a nurse's note dated November 8, 2023, which indicated the nurse entered room resident was seen sitting on the bathroom floor facing the sink .Resident was laid down in bed about 60 minutes prior to fall for a nap. Resident ambulated unassisted to the bathroom and fell . Review of facility documentation regarding Resident 106's fall on November 8, 2023 revealed Resident 106's fell at 3:30 p.m. Review of the IDT (Interdisciplinary Team) Review revealed the resident fell in the bathroom attempting to toilet self without staff assistance. The new intervention approved by the IDT was to offer the resident toileting on the last round of the 7-3 (day) shift. Review of Resident 106's care plan revealed the resident's care plan for falls was updated on November 9, 2023, with the intervention to offer resident toileting on the last round of the 7-3 shift. Review of Resident 106's progress notes revealed a nurse's note dated November 22, 2023, which stated that the nurse was called to the resident's room because the resident was found on the floor, and resident was seen lying on her back with her head facing the footboard on her fall mat. Resident was wearing shirt, pants, regular socks, and a soiled brief. Resident was laid down for a nap after lunch. Some time between then and the fall resident had a large BM (bowel movement) which made her restless. Resident attempted to ambulate unassisted to the bathroom. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of facility documentation regarding Resident 106's November 22 nd fall revealed the resident's fall occurred at 3:00 p.m. Review of the IDT review revealed the new intervention was to offer the resident toileting prior to the end of 7-3 shift. Review of Resident 106's progress notes revealed a nurse's note on November 23, 2023, which stated called to resident room around [3:30 p.m.] resident observed laying on her back on top of her fall mat. head by footboard of the bed and feet towards the wall. wheelchair at the end by resident head .prior to fall resident was resting in bed .nursing intervention check on resident at the end of 7-3 shift, if resident is awake offer resident [to get out of bed.] Review of facility documentation regarding Resident 106's November 23rd fall failed to reveal when the resident was last toileted prior to the fall. Further review of Resident 106's progress notes revealed a nurse's note dated December 1, 2023, which stated: At about [3:10 p.m.] this writer was walking out of the B wing nurses station and heard a thud. This writer then heard sounds coming from [Resident 106's room] and walked in and observed the resident on the fall matt, beside her bed, laying on her back, with her head resting on the bottom edge of the bedside stand. Resident was able to move all extremities per usual. Blood was noted on resident's hand and when staff assisted her to a sitting position, it was noted that the back of the resident's head was bleeding. Upon inspection, it was noted that the resident had a laceration that was bleeding and needed stitches. [Physician] also heard the thud and assessed the resident's head wound, agreeing that the resident needed stitches. When asked what she was trying to do, the resident stated that she had to go to the bathroom [ROOM NUMBER] notified. Review of Resident 106's emergency room documentation revealed the resident was diagnosed with a closed head injury and required staples to the head. Review of Resident 106's nurse's note revealed the resident returned from the hospital the same night at approximately 9:15 p.m. with three staples to the laceration to the back of the head. Review of facility documentation revealed a witness statement from nurse aide, Employee E7, taken on December 1, 2023, which indicated: I was told to toilet resident and lay her down in bed for a nap after lunch. I did not know I was supposed to get her out of bed before 3pm. The facility's failure to follow Resident 106's care plan by offering toileting at the end of 7-3 shift, resulting in Resident 106's fall with laceration to the head requiring staples, was discussed with and confirmed with the Nursing Home Administrator and Assistant Director of Nursing on March 29, 2024, at 12:00 p.m. Review of Resident 39's diagnosis list includes Parkinson's Disease (disorder of the central nervous system that affects movement, often including tremors), and Depression. Review of Resident 39's Annual Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) dated March 1, 2024, revealed the Resident had a moderate cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the nursing progress notes dated February 4, 2024, at 6:25 p.m., revealed that the resident was in their power chair with a wheelchair leg rest looking for another resident who he thought had threatened him/her. When asked, Resident 39 reported that another resident shook a fist at him/her and said something. Will continue to observe. Review of the nursing progress notes dated February 9, 2024, at 2:17 p.m., revealed Resident 39 was in the lobby showing signs of aggression towards another resident. Both residents were observed yelling at each other, staff separated them and redirected them to different locations. The same note indicated that Resident 39 walked with the social worker back to the unit and expressed a desire to find a wheelchair leg to come after the other resident. After speaking to the resident, he/she calmed down and stated that he/she would stay away from the other resident. 15-30 minutes later, Resident 39 was seen coming back to the lobby looking for the other resident, he/she was redirected back to the unit. Interview conducted with licensed social worker Employee E10 on March 29, 2024, at 9:40 a.m. at which time, Employee E10 reported, she/he spoke with the resident after the February 4, 2024, incident but did not have any recollection of the event. Review of Resident 39's clinical records failed to reveal a comprehensive care plan for Resident 39's aggressive behavior towards another resident was developed after the above incidents. The facility was unable to provide documentation of a comprehensive care plan for Resident 39's aggressive behavior towards another resident was developed. The above information regarding Resident 39 was conveyed to the Nursing Home Administrator on March 29, 2024, at 1:00 p.m. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 210.18(b)(3)(e)(1) Management 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on clinical records review and staff interview, it was determined that the facility failed to timely provide wound treatment to an Unstageable Pressure Ulcer (Obscured full-thickness skin and tissue loss) for one of the nine residents reviewed (Resident 122). Findings include: Review of Resident 122's clinical records review, and skin admission assessment revealed Resident 122 was admitted to the facility on [DATE], with an unstageable wound to the right heel with a measurement of 10.0 x 9.0 cm, depth unable to determine, 80% necrotic tissue, foul smelling. The treatment plan was to apply betadine and cover with dressing. Review of Resident 122's skin care plan developed on February 9, 2024, revealed an intervention to administer wound treatment per the physician's order. Review of the February 2024, Treatment Administration Record (TAR) failed to reveal a treatment order for the right heel identified upon admission on February 9, 2024. Review of the wound consult report dated February 14, 2024, revealed the following assessment: Right heel unstageable, 7.5 x 10.0 x 0.5 cm. 50% slough (A non-viable yellow, tan, gray, green, or brown tissue; usually moist, can be soft, stringy and mucinous in texture). Treatment recommendations are as follows: Cleanse with Dakin's, apply Santyl (A topical medication used for removing damaged or burned skin to allow for wound healing and growth of healthy skin), alginate, and cover with dressing. Review of Resident 122's clinical record including February 2024 TAR revealed Resident 122's right heel unstageable wound did not receive treatment until seen by the wound consultant on February 14, 2024, five days after the wound was identified on admission. An interview with the wound nurse Employee E6 on March 29, 2024, confirmed that the wound treatment was not put in place when identified on admission. Employee E6 confirmed Resident 122's right heel unstageable wound did not have a documented wound treatment until seen by the wound consultant on February 14, 2024. The facility failed to ensure Resident 122's right heel unstageable wound received treatment timely. 28 Pa. Code 210.18(b)(3)(e)(1) Management 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46166 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide the appropriate monitoring, care, and services for two of four residents receiving parenteral nutrition (Residents 18 and 37) which resulted in actual harm to Resident 18, who developed an infection to the site of the parenteral tube feed which caused pain, multiple hospital trips, and required IV (intravenous) antibiotic therapy. Findings include: Observation of Resident 18 on March 26, 2024, and March 27, 2024, revealed the resident had a percutaneous endoscopic gastrostomy (PEG tube - tube placed through the abdomen directly into the stomach to provide nutrition and medication when oral intake is not adequate). Further observation revealed the resident had an IV placed in the right arm. Review of Resident 18's care plan for the PEG tube revealed an intervention added September 6, 2022, to provide care to the tube site per (physician) orders. Review of Resident 18's physician orders revealed an order dated April 2, 2023, and discontinued October 11, 2023, to cleanse the PEG insertion site with soap and water, apply Bacitracin (antibiotic ointment) and leave open to air every shift for skin care. Review of Resident 18's October 2023, November 2023, December 2023, and January 2024 Treatment Administration Records (TARs) failed to reveal evidence of documented care to the PEG insertion site until January 11, 2024, when an order was obtained to apply clotrimazole 1% (antifungal) cream to the PEG site twice a day for yeast for 10 days. Review of Resident 18's February 2024 TAR failed to reveal evidence of documented care to the PEG insertion site. Review of Resident 18's progress notes revealed a provider note dated January 11, 2024, when the resident returned from a hospitalization occurring January 7, 2024, until January 10, 2024, for gastritis (inflammation of the stomach). Further review of the progress note revealed, while at the hospital, the resident's PEG site was believed to be infected and positive for a yeast infection, so the resident was started on clotrimazole until January 21, 2024. Additional review of Resident 18's progress notes revealed a nurse's note on February 24, 2024, which stated that the resident's PEG tube bandage was changed, and skin surrounding is red/irritated/moist and painful to the touch. Cleaned with [normal saline] and bacitracin applied. Further review of Resident 18's progress notes revealed a nurse's note on February 27, 2024, which stated that the resident's PEG tube bandage was changed, and skin surrounding is red/irritated/moist and painful to the touch. Cleaned with [normal saline] and bacitracin applied. Will continue to monitor. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	Further review of Resident 18's clinical record failed to reveal evidence that the provider was made aware of the resident's PEG site following the February 24th and February 27th nursing progress notes. Review of Resident 18's progress note revealed a nurse's note dated March 2, 2024, which indicated Resident has brown color drainage from [PEG] site. Drainage has a foul odor. Resident abdomen area is distended. Resident 18 was sent to the hospital at approximately 4:20 p.m. and returned the same day at 10:45 p.m. with a diagnosis of abrasion of abdominal wall with infection and an order for Cephalexin (Keflex) (antibiotic) 500 milligrams every 12 hours from March 3, 2024, through March 17, 2024. Further review of Resident 18's progress notes revealed a nurse's note dated March 6, 2024, indicating the PEG site was fire red, active bleeding this shift. [NAME] drainage. Area cleansed and dressing applied [twice.] .Right side of stoma site bubbling liquid. Asked resident if in pain at first said no. Explained to resident the importance of letting us know. He then said he is in pain Culture collected. Additional review of Resident 18's progress notes revealed a nurse's note dated March 7, 2024, indicating Resident peg site is red with purulent drainage and blood. Area cleaned and dry dressing applied. Further review of Resident 18's progress notes revealed a nurse's note dated March 8, 2024, at 6:59 a.m. indicating Resident with moderate amount blood from [peg] tube. Blood bubbling from stoma site. Area cleansed and dressing applied. Gown and sheet needed to be changed also. Additional review of Resident 18's clinical record revealed a progress note dated March 8, 2024 at 3:15 p.m. indicating Peg tube [stoma] has bloody and dark drainage seeping around tubing. Air and 'bubbling' noted around site. Cleaned and dressing applied. Further review of Resident 18's progress notes revealed a nurse's note on March 9, 2024, at 1:57 a.m. indicating Notified by Nurse that Resident is having significant increased bleeding [and] possible stool coming out around [PEG] tube. The physician was contacted for orders to send to the emergency room . Further review of Resident 18's progress notes revealed the resident was sent to the emergency room of three different hospitals and returned to the facility the same day March 9, 10, and 11, 2024, due to no sources of bleeding being identified and the resident already being on antibiotics. Further review of Resident 18's progress notes revealed a provider note on March 12, 2024, which stated that the resident's culture returned positive for klebsiella (bacteria), MRSA (bacteria resistant to many antibiotics), and candida (yeast.) The resident's Keflex was discontinued and the resident was started on Bactrim (antibiotic) DS one tablet twice daily for 14 days. Review of Resident 18's March 2024 TAR revealed the resident was ordered to have the PEG site cleansed with normal saline and covered with a dry dressing twice daily from March 14, 2024, through March 18, 2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0693

Level of Harm - Actual harm

Residents Affected - Few

Review of Resident 18's progress notes revealed the physician discontinued the treatment on March 18, 2024, and ordered to cleanse the site with Hibiclens (antiseptic skin cleanser) twice daily. Further review of Resident 18's progress notes revealed the resident was started on fluconazole (antifungal medication) 200mg daily for seven days and Lotrimin (antifungal) cream daily for seven days.

Further review of Resident 18's progress notes revealed a physician's note on March 25, 2024, which stated: follow up of abdominal abscess/dermatitis near his PEG tube insertion .Bactrim DS twice a day for the infection. He is also being seen by our wound physician. His wound culture returned positive for Klebsiella pneumoniae as well as MRSA, both susceptible to Bactrim. Despite this, he does not seem to be improving and continues to have dark brown mucus and bloody drainage from the PEG tube site. The physician ordered daptomycin (antibiotic) 350 mg IV every 24 hours for 7 days at this time.

Observation of Resident 18's PEG tube care with licensed nurse, Employee E3, who is also the Infection Preventionist, on March 29, 2024, at 9:20 a.m. revealed the PEG site was red with dark drainage surrounding the site. Resident 18 complained of pain during care. Interview with Employee E3 at this time revealed all residents with PEG tubes are expected to have at least daily care to the PEG site to prevent infection.

Interview with the Nursing Home Administrator and Assistant Director of Nursing on March 29, 2024, at 12:00 p.m. confirmed that Resident 18 did not receive daily consistent PEG tube care from October 2023 until March 2024.

The facility failed to provide consistent, daily PEG tube care to Resident 18, which resulted in the actual harm of infection, multiple hospital trips, antibiotics, and pain.

Review of facility's enteral tube feeding via continuous pump policy with a revision date of November 2018 states Check the enteral nutrition label against the order before administration. Check the following information a. resident name, ID and room number, b. type of formula, date and time formula was prepared, rate of administration (mL/hour). The policy also states under Initiate feeding the following On formula label document initials, date, and time the formula was hung/administered, the resident's name and flow rate. On flush bag (if applicable) document initials, date and time the water was hung/administered, the resident's name and prescribed flush amounts/intervals.

Clinical medical record review for Resident 37 revealed an active physician's order dated January 19, 2024, that instructed staff to provide enteral feeding (provision of food and fluids via the gastrointestinal tract, e.g., directly into the stomach, not through the mouth) of Isosource 1.5, 75 ml (milliliters) continuously with 60 ml water every hour, start feeding at 4pm, stop at 10am.(for a total of 1350 ml of Isosource and 1080 ml of water).

Clinical medical record review of Resident 37 revealed the following diagnosis: Generalized Idiopathic Epilepsy and epileptic syndromes (causes seizures that involve electrical discharges all over the brain at the same time), Quadriplegia (paralysis of all four limbs and the torso), Oropharyngeal Dysphagia (affects the ability to swallow).

Observation of Resident 37 on March 27, 2024, at 9:39 A.M. revealed Isosource 1.5 liquid nutrition infusing via a pump set at a rate of 70 ml per hour. Additional observations revealed the Isosource did not contain the initials, date, or time the formula was hung.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER: Susquehanna Health and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 745 Old Chickies Hill Road Columbia, PA 17512	

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)
F 0693 Level of Harm - Actual harm Residents Affected - Few	Observations of Resident 37 on March 28, 2024, at 8:17 A.M. revealed Isosource 1.5 liquid nutrition infusing via a pump set at a rate of 70 ml per hour, with a total volume of 1828 ml Isosource infused and a total volume of 1624 ml of water flushed. Isosource 1.5 did not contain the initials, date, or time the formula was hung. Interview conducted with the Assistant Director of Nursing (ADON), Nursing Home Administrator (NHA), and Registered Dietitian Employee (E4), on March 29, 2024, at 10:02 A.M. confirmed Resident 37's Isosource 1. 5 rate should have been set to 75 ml/hr. Observation of Resident 37's feed pump on March 29, 2024 at 10:38 A.M. with the ADON and E4 revealed the feed pump was set to 70 ml/hr and the Isosource 1.5 was missing the initials, date, and time the bag was hung. ADON performed a 24-hour lookback function on Resident 37's pump. The 24 hour lookback revealed Resident 37 only received 1083 ml of Isosource 1.5 in a 24 hour period. Additional observations on March 29, 2024 at 10:40 A.M. revealed Resident 37's pump was still active and infusing Isosource 1.5. The above information was confirmed by the Assistant Director of Nursing and Employee E4 at 10:41 A.M 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Susquehanna Health and Wellness Center	745 Old Chickies Hill Road Columbia, PA 17512

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 41765 Based on clinical records review and staff interview, it was determined that the facility failed to provide behavioral services and treatment for a resident exhibiting aggressive behavior towards another resident for one 30 residents reviewed (Resident 39). Findings include: Review of resident 39's diagnosis list includes Parkinson's Disease (disorder of the central nervous system that affects movement, often including tremors), and Depression. Review of Resident 39's Annual Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) dated March 1, 2024, revealed that the Resident had a moderate cognitive impairment. Review of Resident 39's nursing progress notes dated February 4, 2024, at 6:25 p.m., revealed the resident was in their power chair with a wheelchair leg rest looking for another resident who he/she thought had threatened him/her. When asked, Resident 39 reported another resident shook a fist at him/her and said something. Will continue to observe. Interview with licensed Social Worker Employee E10 was conducted on March 29, 2024, at 9:40 a.m. Employee E10 reported that she/he spoke to the resident the day after but did not have any recollection of the event. Review of Resident 39's clinical record failed to reveal the physician was notified of the event and the Resident's behavior. Additaional review failed to reveal any additional interventions implemented by the facility. Review of Resident 39's nursing progress notes dated February 9, 2024, at 2:17 p.m., revealed Resident 39 was in the lobby showing signs of aggression towards another resident. Both residents were observed yelling at each other, staff separated them and redirected them to different locations. The same note indicated that Resident 39 walked with the social worker back to the unit and expressed a desire to find a wheelchair leg to come after the other resident. After speaking to the resident, he/she calmed down and stated that he/she would stay away from the other resident. 15-30 minutes later, Resident 39 was seen coming back to the lobby looking for the other resident, he/she was redirected back to the unit. Review of Resident 39's clinical record failed to reveal the physician was notified of the incident and the resident's aggressive behavior. The facility was unable to provide documented evidence of behavioral services and treatment were provided to Resident 39 after two incidents of physical aggression towards another resident. The above was conveyed to the Nursing Home Administrator on March 29, 2024, at 1:00 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER: Susquehanna Health and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 745 Old Chickies Hill Road Columbia, PA 17512	

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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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure Resident 39 was provided with behavioral services and treatment for showing aggressive behavior towards another resident. 28 Pa. Code 210.18(b)(3)(e)(1) Management 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Susquehanna Health and Wellness Center	745 Old Chickies Hill Road Columbia, PA 17512

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41765 Based on observations and staff interviews, it was determined that the facility failed to ensure a sanitary environment in the beverage area in the kitchen. Findings include: Observation conducted in the kitchen in the presence of Dietitian Employee E5 on March 26, 2024, at 10: 40 a.m., the following was observed: A hole with an approximate size of half a foot in length and one foot in width was observed on the bottom wall behind the beverage area. The right-side wall of the beverage area was observed with one baseball-sized hole, one ping-pong-sized hole, and a crack on the wall approximately two feet long. Observation conducted on March 29, 2024, at 11:40 a.m., in the presence of Employee E5 revealed the same observation above. Interview with Employee E5 was conducted on March 29, 2024, Employee E5 was unable to determine how long the cracks and holes on the walls in the beverage area had been present. The facility failed to ensure a sanitary environment, and kitchen walls free from holes and cracks in the beverage area of the kitchen. 42 CFR 483.60(i)(2) Food Procurement, Store/Prepare/Serve-Sanitary 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management