

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 08/22/2024
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>46994</p> <p>Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to provide care in a manner that maintained dignity for one of 56 residents reviewed (Resident 48).</p> <p>Findings include:</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 48, dated August 6, 2024, indicated that the resident was understood and able to understand others, required substantial to moderate assistance with personal hygiene care, and had diagnoses that included diabetes.</p> <p>Observations of Resident 48 on August 19, 2024, at 11:00 a.m. revealed that she was lying in her bed with many long, white hairs protruding from under her chin. An interview with Resident 48 at that time revealed that she does not like having the long hair on her chin because it sometimes gets caught on her blankets and pulls her skin.</p> <p>Observations of Resident 48 on August 21, 2024, at 7:47 a.m. and on August 22, 2024, at 12:07 p.m. revealed that the resident continued to have many long, white hairs protruding from under her chin.</p> <p>Review of Resident 48's clinical record, including nurses' notes and nurse aide documentation, revealed no evidence that the resident was offered or refused to have her facial hair removed.</p> <p>Interview with the Director of Nursing on August 22, 2024, at 12:10 p.m. revealed that staff should have provided Resident 48 care that included removing her visible facial hair.</p> <p>28 Pa. Code 201.29(c) Resident Rights.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>46994</p> <p>Based on a review of clinical records, as well as staff interviews, it was determined that the facility failed to determine a resident's preference for bathing for one of 56 residents reviewed (Resident 48).</p> <p>Findings include:</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 48, dated August 6, 2024, indicated that the resident was understood and able to understand others; required substantial to moderate assistance with personal hygiene care; had a preference that was very important to her to choose between a tub bath, shower, bed bath, or sponge bath; and had diagnoses that included diabetes.</p> <p>Review of the care plan for Resident 48, dated August 2, 2024, revealed that the resident required assist of one staff for bathing; however, it did not indicate if the resident preferred showers, tub baths or bed baths.</p> <p>Interview with the Director of Nursing on August 22, 2024, at 2:10 p.m. revealed that there was no documented evidence that Resident 48's shower preferences were identified to enable staff to provide her bathing preference.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>

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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>19102</p> <p>Based on clinical record reviews and observations, as well as resident and staff interviews, it was determined that the facility failed to ensure that in preparation for room changes each resident received written notice, including the reason for the change, before the resident's room or roommate was changed for one of 56 residents reviewed (Resident 139).</p> <p>Findings include:</p> <p>Review of Resident 139's clinical record and quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 139, dated July 1, 2024, revealed that the resident could understand others and make herself understood and was cognitively intact.</p> <p>A social service note, dated August 12, 2024, at 9:45 a.m., revealed that Resident 139 toured the A-unit, was introduced to several nursing staff on the unit, and was in agreement with the room at that time.</p> <p>A facility census report revealed that Resident 139 was moved from the B-wing to a room on the A unit on August 12, 2024. There was no documented evidence that Resident 139 was provided a written notice prior to the room change, including the reason for the change.</p> <p>Observations and interview with Resident 139 on August 19, 2024, at 12:12 p.m. revealed that she was moved from the B-unit to the A-unit and did not know the reason why she had to move.</p> <p>Interview with the Nursing Home Administrator on August 21, 2024, at 3:23 p.m. confirmed that there was no documented evidence that Resident 139 was provided a written notice regarding the room change and the reason for the move.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.29(a) Resident Rights.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>19102</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to notify the resident and resident's representative, in writing, regarding the reason for hospitalization for five of 56 residents reviewed (Residents 18, 36, 38, 77, 85).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 18, dated June 17, 2024, indicated that the resident was cognitively impaired, required assistance from staff for his daily care needs, and had diagnoses that included dementia.</p> <p>A nursing note for Resident 18, dated June 11, 2024, revealed that the resident was transferred to the hospital for evaluation of abdominal pain and to have his indwelling urinary catheter flushed or replaced. He was admitted to the hospital with a urinary tract infection.</p> <p>There was no documented evidence that a written notice of Resident 18's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer.</p> <p>A quarterly MDS assessment for Resident 36, dated July 23, 2024, indicated that the resident was understood and able to understand others, required substantial to moderate assist from staff for his personal care needs, and had diagnoses that included dementia.</p> <p>A nursing note for Resident 36, dated June 7, 2024, at 6:41 a.m., revealed that the resident had an unwitnessed fall resulting in a possible right arm fracture. The physician was notified, and the resident was sent to the emergency room for evaluation.</p> <p>A nursing note for Resident 36, dated July 4, 2024, at 10:46 p.m., revealed that the resident had a significant change in condition. The certified registered nurse practitioner was notified, and the resident was sent to the emergency room for evaluation.</p> <p>There was no documented evidence that a written notice of Resident 36's transfers to the hospital were provided to the resident or the resident's representative regarding the reason for transfer.</p> <p>A quarterly MDS assessment for Resident 38, dated May 21, 2024, indicated that the resident was severely cognitively impaired, was dependent on staff for personal care needs, and had diagnoses that included idiopathic epilepsy (a genetic seizure disorder).</p> <p>A nursing note for Resident 38, dated May 7, 2024, at 2:40 p.m., revealed that the resident had a seizure and was not responding to treatments provided and his condition was worsening; therefore, he was transferred to the emergency room for evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A nursing note for Resident 38, dated June 21, 2024, at 6:34 a.m., revealed that the resident's feeding tube came out of his body. The physician was notified, and the resident was sent to the emergency room for evaluation.</p> <p>There was no documented evidence that a written notice of Resident 38's transfers to the hospital were provided to the resident or the resident's representative regarding the reason for transfer.</p> <p>A quarterly MDS assessment for Resident 77, dated May 2, 2024, indicated that the resident was moderately cognitively impaired, required assistance from staff for personal care needs, and had diagnoses that included dementia and heart failure.</p> <p>A nursing note, dated June 24, 2024, at 7:46 p.m. revealed that Resident 77 was found coughing and wheezing, was flushed, and had an oxygen saturation (amount of oxygen in the blood) in the 70's (normal 95-100 percent). The physician was notified, and the resident was transferred to the hospital.</p> <p>There was no documented evidence that a written notice of Resident 77's transfer to the hospital was provided to the resident or the resident's representative regarding the reason for transfer.</p> <p>A quarterly MDS assessment for Resident 85, dated May 16, 2024, indicated that the resident was severely cognitively impaired, required assistance from staff for personal care needs, and had diagnoses that included dementia, seizure disorder, and a stroke.</p> <p>A nursing note, dated July 27, 2024, at 10:10 a.m. revealed that Resident 85 was observed lying in bed with his eyes closed with right-sided facial droop and facial edema (swelling). The resident stated, I don't feel well, and the physician was notified and an order was received to send him to the hospital for evaluation and treatment.</p> <p>A nursing note, dated July 27, 2024, at 12:28 p.m. revealed that Resident 85 was admitted to the hospital with a diagnosis of encephalopathy (a condition that causes brain dysfunction).</p> <p>There was no documented evidence that a written notice of Resident 85's transfer to the hospital was provided to the resident or the resident's representative regarding the reason for transfer.</p> <p>Interview with the Nursing Home Administrator on August 20, 2024, at 3:48 p.m. confirmed that the facility did not provide a written notice to the residents or their responsible party when a resident was transferred to the hospital.</p> <p>28 Pa. Code 201.25 Discharge Policy.</p> <p>28 Pa. Code 201.29(f)(g) Resident Rights.</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012</p> <p>Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that comprehensive admission Minimum Data Set assessments were completed in the required time frame for nine of 56 residents reviewed (Residents 22, 82, 112, 120, 131, 136, 153, 155, 157).</p> <p>Findings include:</p> <p>The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October, 2023, indicated that an admission MDS assessment was to be completed no later than 14 days (admitted + 13 calendar days) following admission.</p> <p>A comprehensive admission MDS assessment for Resident 22, dated June 27, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on July 9, 2024, which was 19 days after admission.</p> <p>A comprehensive admission MDS assessment for Resident 82, dated May 22, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on June 3, 2024, which was 20 days after admission.</p> <p>A comprehensive admission MDS assessment for Resident 112, dated May 3, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on May 13, 2024, which was 16 days after admission.</p> <p>A comprehensive admission MDS assessment for Resident 120, dated June 27, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on July 8, 2024, which was 18 days after admission.</p> <p>A comprehensive admission MDS assessment for Resident 131, dated June 13, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on June 21, 2024, which was 15 days after admission.</p> <p>A comprehensive admission MDS assessment for Resident 136, dated May 14, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on May 23, 2024, which was 16 days after admission.</p> <p>A comprehensive admission MDS assessment for Resident 153, dated June 12, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on June 21, 2024, which was 16 days after admission.</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A comprehensive admission MDS assessment for Resident 155, dated June 24, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on July 2, 2024, which was 16 days after admission.</p> <p>A comprehensive admission MDS assessment for Resident 157, dated June 25, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on July 4, 2024, which was 16 days after admission.</p> <p>An interview with Nursing Home Administrator on August 22, 2024, at 3:29 p.m. confirmed that the admission MDS assessments listed above were not completed within the required time frames.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p>

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>38012</p> <p>Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that Quarterly Minimum Data Set assessments were completed within the required timeframe for seven of 56 residents reviewed (Residents 21, 26, 64, 70, 98, 139, 148).</p> <p>Findings include:</p> <p>The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of residents' abilities and care needs), dated October 2019, indicated that the completion date for a quarterly assessment is the Assessment Reference Date (ARD - the last day of an assessment's look-back period) plus 14 days. A quarterly assessment is due every 92 days (ARD of most recent assessment + 92 days).</p> <p>A quarterly MDS assessment for Resident 21, with an ARD of May 10, 2024, was completed on May 27, 2024, which was three days late.</p> <p>A quarterly MDS assessment for Resident 26, with an ARD of May 10, 2024, was completed on May 27, 2024, which was three days late.</p> <p>A quarterly MDS assessment for Resident 64, with an ARD of May 13, 2024, was completed on May 28, 2024, which was one day late.</p> <p>A quarterly MDS assessment for Resident 70, with an ARD of May 13, 2024, was completed on May 28, 2024, which was two days late.</p> <p>A quarterly MDS assessment for Resident 98, with an ARD of May 9, 2024, was completed on May 24, 2024, which was one day late.</p> <p>A quarterly MDS assessment for Resident 139, with an ARD of May 9, 2024, was completed on May 24, 2024, which was one day late.</p> <p>A quarterly MDS assessment for Resident 148, with an ARD of May 24, 2024, was completed on June 9, 2024, which was two days late.</p> <p>An interview with Nursing Home Administrator on August 22, 2024, at 3:29 p.m. confirmed that the quarterly MDS assessments listed above were not completed within the required time frames.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19102</p> <p>Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for seven of 56 residents reviewed (Residents 28, 52, 53, 91, 94, 139, 162).</p> <p>Findings include:</p> <p>The Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated [DATE], revealed that Section O0110G1b (non-invasive mechanical ventilator) was to be checked if a CPAP/BIPAP device (respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle) was used while a resident within the last 14 days.</p> <p>Physician's orders for Resident 28, dated [DATE], included an order for the resident to use a CPAP/BIPAP with distilled water every evening and night shift.</p> <p>A quarterly MDS assessment for Resident 28, dated [DATE], revealed that Section O0110G1b was not checked, indicating that the resident did not use a CPAP/BIPAP device during the seven-day assessment period.</p> <p>Review of the MAR for Resident 28, dated [DATE], revealed that the resident used a CPAP/BIPAP device every night during the seven-day assessment period.</p> <p>The RAI User's Manual, dated [DATE], indicated that Section P0200 (alarms) was to be coded if the resident had various types of alarms in use. This section was to be coded (A) if a bed alarm was used, (B) if a chair alarm was used, (C) if a floor mat alarm was used, (D) if a wander/elopement alarm was used, (F) if any other alarm was used during the seven-day look-back period.</p> <p>A quarterly MDS assessment for Resident 52, dated, dated [DATE], revealed that Section P0200 was coded D, indicating that the resident used a wander/elopement alarm.</p> <p>Review of the clinical record for Resident 52 for July and [DATE] revealed no documented evidence that the resident was using a wander/elopement alarm during the MDS assessment look-back period.</p> <p>The RAI User's Manual, dated [DATE], revealed that Section H0100 (bowel and bladder appliances) was to be coded (A) if the resident had an indwelling catheter (small tube inserted into the bladder to drain urine), (B) if the resident had an external catheter, (C) if the resident received intermittent catheterization (insertion and removal of a catheter to drain urine), and (Z) if none of the above applied during the seven-day look-back period. Section H0300 (urinary incontinence) was to be coded (0) if the resident was always continent, (1) if the resident occasionally incontinent of urine, (2) if the resident was frequently incontinent of urine, (3) if the resident was always incontinent of urine, and (9) if the resident's urinary continence was not rated because the resident had a catheter.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A care plan for Resident 53, dated [DATE], indicated that the resident had a suprapubic catheter for overactive bladder symptoms unresponsive to multiple interventions.</p> <p>An admission MDS assessment for Resident 53, dated [DATE], revealed that Section H0100 was coded (A) indicating that the resident had an indwelling catheter during the seven-day look-back assessment period and Section H0300 was coded (3) always incontinent, indicating the resident was always incontinent of urine during the seven-day look-back assessment period.</p> <p>The Long-Term Care Facility RAI User's Manual, dated [DATE], revealed that Section N0415C1 should be checked if the resident received an antidepressant medication and Section N0415I1 was to be checked if the resident received an anti-platelet medication during the seven-day assessment period.</p> <p>Physician's orders for Resident 91, dated [DATE], included an order for the resident to receive 81 milligrams (mg) of aspirin (antiplatelet) one time a day, and physician's orders, dated [DATE], included an order for the resident to receive 60 mg of duloxetine (an antidepressant) one time day.</p> <p>A quarterly MDS for Resident 91, dated [DATE], revealed that Section N0415C1 and Section N0415I1 were not checked, indicating that the resident did not receive an anti-depressant or an anti-platelet medication during the seven-day look-back assessment period.</p> <p>Review of the MAR for Resident 91, dated [DATE], revealed that the resident received 81 mg of aspirin once a day and 60 mg of duloxetine once a day during the seven-day assessment period.</p> <p>The Long-Term Care Facility RAI User's Manual, dated [DATE], revealed that Section N0415B1 should be checked if the resident received an anti-anxiety medication during the seven-day assessment period.</p> <p>Physician's orders for Resident 94, dated [DATE], included an order for the resident to receive 0.25 milliliters (mL) of 2 mg/mL of Ativan (anti-anxiety) at bedtime for anxiety.</p> <p>A quarterly MDS for Resident 94, dated [DATE], revealed that Section N0415B1 was not checked, indicating that the resident did not receive an anti-anxiety medication during the seven-day look-back assessment period.</p> <p>Review of the MAR for Resident 94, dated [DATE] revealed that the resident received 0.25 mL of Ativan at bedtime during the seven-day assessment period.</p> <p>Physician's orders for Resident 139, dated [DATE], included an order for the resident to receive 50 mg of Trazadone (anti-depressant) at bedtime for depression.</p> <p>A quarterly MDS for Resident 139, dated [DATE], revealed that Section N0415C was not checked, indicating that the resident did not receive an anti-depressant medication during the seven-day look-back assessment period.</p> <p>Review of the MAR for Resident 139, dated [DATE], revealed that the resident received 50 mg of Trazadone at bedtime during the seven-day assessment period.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Long-Term Care Facility RAI User's Manual, dated October, 2023, revealed that Section A2105 was to capture the discharge status of the resident by checking the appropriate type of discharge from the facility from the types listed, (1) home/community, (2) nursing home (long term care facility), (3) skilled nursing facility (SNF, swing beds), (4) short term general hospital, (5) long term care hospital, (6) inpatient rehabilitation facility, (7) in-patient psychiatric facility, (8) intermediate care facility, (9) hospice (home, non-institutional), (10) hospice (institutional facility), (11) critical access hospital, (12) home under care of organized home health service organization, (13) deceased , and (99) not listed.</p> <p>A discharge MDS for Resident 162, dated [DATE], revealed that section A2105 indicated that the resident was discharged to a short-term general hospital.</p> <p>A physician's order for Resident 162, dated [DATE], included an order to discharge to home with personal belongings on [DATE].</p> <p>Interview on [DATE], at 3:09 p.m. with the Registered Nurse Assessment Coordinator confirmed that the assessments mentioned above were coded incorrectly.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>38012</p> <p>Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs of residents for six of 56 residents reviewed (Residents 8, 25, 27, 38, 53, 120).</p> <p>Findings include:</p> <p>A facility policy for Comprehensive Person-Centered Care Plans, dated June 1, 2024, included that the interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each person. The comprehensive, person-centered care plan was to be developed within seven days of the completion of the required MDS assessment (admission, annual or change in significant status), and no more than 21 days after admission. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated July 17, 2024, revealed that the resident was cognitively impaired, was dependent on staff for personal care needs, and had diagnoses that included diabetes.</p> <p>Physician's orders for Resident 8, dated August 16, 2024, included an order to administer 33 units of Toujeo SoloStar (long-acting insulin used to lower blood sugar) insulin once a day.</p> <p>There was no documented evidence that a care plan was developed to address Resident 8's individual care and treatment needs related to her diabetes diagnosis and diabetes medication use.</p> <p>Interview with the Director of Nursing on August 20, 2024, at 5:09 p.m. revealed that a care plan to address the care needs of Resident 8's diabetes diagnosis and diabetes medication use was not developed and should have been.</p> <p>An admission MDS assessment for Resident 25, dated July 18, 2024, revealed that the resident was understood and able to understand others, was dependent on staff for personal hygiene care, had an indwelling catheter (a small tube inserted into the bladder to drain urine), had diagnoses that included renal insufficiency, and was receiving hospice services.</p> <p>Physician's orders for Resident 25, dated July 20, 2024, included an order for the resident to have a 16 French (indicates a size) foley catheter (type of an indwelling catheter).</p> <p>Interview with the Director of Nursing on August 20, 2024, at 12:47 p.m. revealed that Resident 25 required enhanced barrier precautions (infection control intervention designed to reduce transmission of multidrug-resistant organisms that requires gown and glove use during high contact resident care activities) because of her indwelling catheter; however, a care plan to address the care needs associated with enhanced barrier precautions related to her indwelling catheter was not developed and should have been.</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 - Some</p>	<p>An annual MDS for Resident 27, dated June 7, 2024, indicated that the resident was cognitively intact. Physician's orders for Resident 27, dated August 14, 2024, included an order for the resident to receive 1 gram of Vancomycin (antibiotic) through her Peripherally Inserted Central Catheter (PICC- a long thin tube inserted through a vein in the arm and passed to the larger veins near the heart that can be used for a prolonged period of time) for osteomyelitis (bone infection).</p> <p>Resident 27's care plan, dated May 2, 2022, revealed that it did not include any information or interventions related to the resident's PICC line, infection with antibiotic treatment, or enhanced barrier precautions.</p> <p>An interview with the Director of Nursing on August 20, 2024, at 12:48 p.m. confirmed that Resident 27's care plan did not include anything regarding the resident's infection, PICC line, antibiotic treatment, or Enhanced Barrier Precautions and it should have.</p> <p>A quarterly MDS assessment for Resident 38, dated May 21, 2024, revealed that the resident was cognitively impaired, was dependent on staff for all care needs, had an indwelling catheter, and had diagnoses that included neurogenic bladder.</p> <p>Physician's orders, dated June 21, 2024, included an order for the resident to have a 16 French foley catheter for neuromuscular dysfunction of his bladder.</p> <p>Observations of Resident 38's room on August 19, 2024, at 11:30 a.m. revealed that the resident was lying in bed with a foley catheter drainage bag hanging on his bed. A sign was posted on the door to his room indicating that enhanced barrier precautions were required when providing care to the resident. Resident 38's care plan did not include anything regarding enhanced barrier precautions related to the indwelling catheter.</p> <p>An admission MDS assessment for Resident 53 dated June 8, 2024, revealed that the resident was understood and able to understand others, was independent with personal hygiene care, had an indwelling catheter, and had diagnosis that included Parkinson's disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination).</p> <p>Physician's orders for Resident 53, dated July 1, 2024, included for the resident to have a 16 French suprapubic catheter (tube that is used to drain urine from the bladder through a cut in the abdomen) for urinary retention.</p> <p>Observations of Resident 53's room on August 19, 2024, at 11:30 a.m. revealed that the resident sitting in bed with a urinary catheter drainage bag attached to his leg. A sign was posted on the door to his room indicating that enhanced barrier precautions were required when providing care to the resident. Resident 53's care plan did not include anything regarding enhanced barrier precautions related to the indwelling catheter.</p> <p>Interview with the Director of Nursing on August 20, 2024, at 12:47 p.m. revealed that Residents 38 and 53 did require enhanced barrier precaution because of their indwelling catheters; however, care plans to address the care needs associated with enhanced barrier precautions related to their indwelling catheters were never developed and should have been.</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 - Some</p>	<p>A quarterly MDS for Resident 120, dated July 15, 2024, revealed that the resident was cognitively intact and that he was on a blood thinner. Physician's orders for Resident 120, dated June 21, 2024, included an order for the resident to receive 5 milligrams (mg) Apixaban (blood thinner) two times per day.</p> <p>Resident 120's care plan, dated June 21, 2024, did not include any information or interventions related to the use of a blood thinner.</p> <p>Interview with the Director of Nursing on August 20, 2024 at 12:48 p.m. revealed that Resident 120's care plan did not included anything regarding the resident's use of Apixaban and it should have.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy.</p> <p>28 Pa. Code 211.12(d)(1)(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>38012</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physicians orders were followed for three of 56 residents reviewed (Residents 104, 112, 139).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) assessment for Resident 104, dated June 14, 2024, indicated that the resident was understood and able to understand others, was dependent on staff for personal hygiene care, and had diagnoses that included cancer and anxiety.</p> <p>Physician's orders for Resident 104, dated June 29, 2024, and August 5, 2024, included an order for the resident to receive 150 milligrams (mg) of Depo-Provera (a medication containing hormones that has been found effective in reducing offensive sexual behavior) intramuscularly one time a day every seven days for impulse disorder.</p> <p>Review of the Medication Administration Record (MAR) for Resident 104 for July 2024 revealed no documented evidence that the resident was administered the Depo-Provera injection as ordered on July 13, 20, and 27, 2024, and August 3, 6, and 20, 2024.</p> <p>Interview with the Director of Nursing on August 22, 2024, at 4:12 p.m. confirmed that there was no documented evidence that Resident 104 was administered Depo-Provera as ordered on the above-mentioned dates.</p> <p>Hospital discharge papers for Resident 112, dated July 17, 2024, revealed that the resident was admitted to the hospital with congestive heart failure and that she required intravenous (IV) Lasix (diuretic) to remove excess fluid. Resident 112's care plan for congestive heart failure, dated July 17, 2024, indicated that the resident should be weighed per the physician's orders.</p> <p>Physician's orders for Resident 112, dated July 18 ,2024, included an order for the resident to be weighed daily and to notify the physician if there was a 2-pound weight gain in one day or a 5-pound weight gain in one week.</p> <p>Resident 112's weight record for July and August 2024 revealed that the resident was not weighed on July 21, 27, 2024, and August 4, 5, 7, 8, 2024.</p> <p>On August 9, 2024, Resident 112 weighed 106.8 pounds and on August 11 the resident weighed 111 pounds. There was no documented evidence that the physician was notified of the 4.2-pound weight gain.</p> <p>On August 15, 2024, Resident 112 weighed 105.6 pounds and on August 16 the resident weighed 108 pounds. There was no documented evidence that the physician was notified regarding the 2.4-pound weight gain in one day.</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 Registered Nurse Supervisor 1 on August 21, 2024, at 11:39 a.m. revealed that she was not notified about Resident 112's weight gains and therefore the physician was not notified. She stated that night shift should have notified her of the weight gains so that she could have notified the physician.</p> <p>Interview with the Director of Nursing on August 21, 2024, at 4:42 p.m. confirmed that staff should have weighed Resident 112 and notified the physician as ordered.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 139, dated July 1 2024, indicated that the resident was alert and oriented, had respiratory failure, and was received an antibiotic.</p> <p>Physician's orders for Resident 139, dated June 30, 2024, included an order for the resident to receive 100 milligrams (mg) of Doxycycline (an antibiotic) two times a day for seven days for a respiratory tract infection.</p> <p>Review of Resident 139's Medication Administration Record (MAR) for July 2024 revealed that the resident did not receive 100 mg of Doxycycline on July 1, 2024, at 9:00 a.m. and 8:00 p.m. as ordered.</p> <p>Interview with the Nursing Home Administrator on August 21, 2024, at 3:23 p.m. confirmed that Resident 139 missed two doses of Doxycycline on July 1, 2024, and did not receive the antibiotic as ordered by the physician.</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 - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>19102</p> <p>Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that each resident received assistance devices to prevent accidents for two of 56 residents reviewed (Residents 109, 125) and failed to protect the safety of other residents from violence from two of 56 residents reviewed (Residents 52, 85).</p> <p>Findings include:</p> <p>A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 109, dated May 15, 2024, revealed that the resident was cognitively intact and required extensive assistance for daily care needs including transfers and locomotion.</p> <p>Observations of Resident 109 on August 19, 2024, at 12:28 p.m. revealed that the resident was sitting in a wheelchair while being transported to her room by Nurse Aide 2. There were no footrests on her wheelchair to prevent her feet from dragging during the transport. An interview with Nurse Aide 2 revealed that he did not know if she had leg rests or not and did not know if she needed them.</p> <p>An interview with the Director of Nursing on August 19, 2024, at 4:38 p.m. confirmed that footrests should have been used when transporting residents in their wheelchairs.</p> <p>A quarterly MDS for Resident 125, dated June 17, 2024, revealed that the resident was understood and able to understand others, required partial to moderate assistance of staff for personal hygiene needs, used a manual wheelchair for mobility, and had diagnoses that included a stroke.</p> <p>Observation of Resident 125 on August 20, 2024, at 11:35 a.m. revealed that she was sitting in her wheelchair being transported the length of a long hallway to her bedroom by Activities Aide 3. There were no footrests on the resident's wheelchair to prevent her feet from dragging during the transport. An interview with Activities Aide 3 at the time of the observation revealed that she was unsure if footrests were to be on the wheelchair when transporting a resident.</p> <p>Interview with the Director of Nursing on August 29, 2024, at 5:05 p.m. confirmed that footrests should have been used when transporting the resident in her wheelchair.</p> <p>A quarterly MDS assessment a mandated assessment of a resident's abilities and care needs for Resident 52, dated, dated August 5, 2024, revealed that the resident was usually understood and was always able to understand others, was dependent on staff for personal hygiene care, and had diagnosis that included Parkinson's disease and schizophrenia.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Care plan for Resident 52, dated March 2, 2022, revealed that the resident had behavior symptoms including hitting himself and others, being resistive with care, running his wheelchair into other people and objects, and inappropriate comments and yelling at others. Staff were to redirect or assist to remove the resident from situations or individuals that cause visual or verbal irritation as allowed, and to monitor the resident while in common areas for aggression including verbal or physical. A care plan, dated May 24, 2022, indicated that the resident had difficulty communicating related to mental retardation. Staff were to maintain his safety and anticipate and meet his needs.</p> <p>A nurse's note for Resident 52, dated June 25, 2024, at 10:53 a.m. revealed that the resident went up to a female resident who was sitting in the hall and attempted to hit her in the face, the resident was able to block him, and then he hit her on the chin with a closed fist. An investigation revealed that the female resident involved was Resident 167 and that the incident did not cause any harm to her. A nurse's note, dated June 25, 2024, at 11:21 a.m., revealed that the resident was sitting in the hall and when another resident went past him, he hit the other resident on the right shoulder. An investigation revealed that the other resident involved was Resident 17 and that the incident did not cause any harm to him. A nurse's note, dated July 25, 2024, at 3:30 p.m., revealed that the resident was rolling himself out of the activity room and while going past a female resident he reached out and punched her in the arm. An investigation revealed that female resident involved was Resident 167 and that the incident did not cause any harm to her.</p> <p>Interview with the Director of Nursing on August 22, 2024, at 2:54 p.m. revealed that Resident 52 did have physical altercations with other residents as identified above and that staff were to monitor the resident's emotions and stimuli and remove him from potentially aggressive situations; however, his intellectual disabilities made it difficult to determine when his behaviors would occur, making it difficult to prevent.</p> <p>A quarterly MDS assessment for Resident 85, dated May 16, 2024, revealed that the resident was cognitively impaired; had physical, verbal, and other behaviors not directed towards others that occurred that occurred one to three days; rejected care; and had diagnoses that included dementia and a stroke.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A care plan for Resident 85, dated August 14, 2024, revealed that the resident was at risk for behaviors symptoms of hitting doors and walls; rejection of care; elopement; wandering into other resident rooms; urinating in inappropriate places; lying in beds; changes in mood related to anxiety, depression delusions, and cognitive loss; verbal and physical agitation (hitting, kicking, pushing, cursing, screaming) towards others; and unwanted interactions with other residents. Interventions included to encourage the resident to a private area where he may openly express his feelings regarding why he was angry and upset; offer opportunities for free expression through creative activities; a psychiatric referral as needed; redirect resident to his own room when expressing and appearing tired; redirect to the bathroom when observed urinating in inappropriate places; redirect and validate resident to ensure safety of self and others; staff to be aware that the resident sits within groups due to protection/safety of peers; use a consistent approach when providing care; assess for physical/environmental changes that may participate changes in mood; discuss feelings regarding current situation; offer choices to enhance sense of control; validate feelings of loss; medications as ordered; allow resident time to respond to directions or requests; be aware of resident personal space; close observation/supervision while in public space; gain the resident's attention before speaking or touching; give the resident a clear and concise explanation of anything about to occur; if behavioral intervention strategies are not working leave (if safe to do so) and reapproach later; keep at the nurse's station so there is a space between residents and redirect him when needed; monitor the resident while approaching other residents and redirect; provide diversional activities; remove from public area when behavior was disruptive/unacceptable; medication review as needed; monitor for resident's increase in voice, body positioning, and other indicators of reactions while near others; monitor surroundings for stimulation of others; and redirect the resident while in other's personal space.</p> <p>A nursing note, dated June 9, 2024, at 9:49 p.m. revealed Resident 85 struck Resident 111 in the left arm and left cheek. The resident's were immediately separated, and Resident 111's skin was assessed and found to be without redness, bruising, or disruption in integrity. Resident 85 was placed under direct and close supervision to maintain safety of all residents. An interdisciplinary note, dated June 10, 2024, indicated that Resident 85's behaviors were escalating and the resident was to have close observation/supervision while in common areas and a complete comprehensive medication review completed by psychiatry. A physician's order, dated June 11, 2024, included an order for the resident to receive 2.5 milligrams (mg) of Zyprexa (antipsychotic) twice a day.</p> <p>A nursing note, dated June 21, 2024, at 9:47 p.m. revealed that Resident 85 walked over to Resident 26 and punched her in the left shoulder. The residents were separated and Resident 26 was assessed with no injuries found. Resident 85's care plan was updated June 22, 2024, to include that he was to be monitored while approaching other residents and to redirect him.</p> <p>A nursing note, dated June 24, 2024, at 6:15 p.m. revealed that Resident 85 hit Resident 99 in the left leg and attempted to hit another resident and a staff member. Resident 85 was re-directed from the other residents and Resident 99 was assessed and had no injuries. Resident 85's care plan was updated on June 25, 2024, to include that he was to be redirected while in other's personal space.</p> <p>A nursing note, dated July 12, 2024, at 12:18 p.m., revealed that Resident 85 was being verbally aggressive towards another resident in the dayroom and proceeded to hit Resident 70 on her left arm. The residents were separated and Resident 70 was assessed to have no injuries. Resident 85's care plan was updated on July 12, 2024, to keep him at the nurse's station so there was a space between residents and to redirect him when needed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A nursing note and witness statements, dated July 14, 2024, at 6:15 a.m. revealed that Resident 85 entered Resident 97's room and punched her in the arm. The residents were separated and there were no injuries noted to either resident. There was no documented evidence that any changes were made to Resident 85's plan of care.</p> <p>A nursing note, dated July 17, 2024, at 9:24 p.m. revealed that Resident 85 and Resident 34 were arguing and exchanged curse words, and Resident 34 hit Resident 85 and then Resident 85 hit Resident 34. This happened a few times and the licensed practical nurse was notified. The residents were separated and there were no injuries noted. A physician's order, dated July 17, 2024, included an order to increase the Zyprexa to 5 mg twice a day, and his care plan was updated to include to monitor him for an increase in his voice, body positioning, and other indicators of reactions while near others. Physician's orders, dated July 19, 2024, included orders to discontinue the Zyprexa and start Risperdal Consta ER intramuscularly every two weeks.</p> <p>A nursing note, dated July 20, 2024, at 3:45 p.m., revealed that Resident 85 was agitated throughout the shift; received Ativan as needed, which was ineffective; was pacing up the halls and approaching other residents, yelling and agitated; and while under supervision abruptly punched Resident 110 on her back. The residents were separated and an order was received to administer 0.5 mg of Haldol (antipsychotic) intramuscularly (injection in the muscle) one time, which was ineffective. Resident 85 continued to approach other residents and while attempting to re-direct Resident 85, he began to strike staff on three occasions. A physician's order was received to send the resident to the hospital.</p> <p>A nursing note, dated July 21, 2024, at 5:35 p.m. revealed that Resident 85 approached Resident 159 at the end of the hall and a verbal argument began. Staff went down the hallway to intervene and Resident 85 pushed Resident 159 from the back, knocking him onto his hands and knees before staff could get there. The residents were separated and there were no injuries noted. There was no documented evidence that any changes were made to Resident 85's plan of care.</p> <p>Following the above incidents, there was no documented evidence that Resident 85's care-planned behavior interventions were revised when they were not effective, and no evidence that an individualized behavior management plan was developed in an attempt to prevent Resident R85's behaviors from affecting the safety of all other residents.</p> <p>Interview with Registered Nurse 1 on August 22, 2024, at 12:16 p.m. revealed that Resident 85 would curse, stand over residents like he was going to hit them, would become aggressive and hit other residents, and anything could set him off. Staff would place him on one-to-one observations, adjust his medications, try activities, and re-direct him, but you could be talking to him one minute and the next minute he would go off.</p> <p>Interview with the Director of Nursing on August 22, 2024, at 2:52 p.m. revealed that the facility tried interventions, but Resident 85 was very impulsive and continued to hit other residents. She indicated that they tried activities, adjusting his medications, and one-to-one observations, but he still hit others.</p> <p>28 Pa. Code 211.10(c)(d) Resident Care Policies.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</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>19102</p> <p>Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to obtain physician's orders for the administration of oxygen for one of 56 residents reviewed (Resident 139).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 139, dated July 1, 2024, revealed that the resident was cognitively intact, had medical diagnoses that included heart failure and respiratory failure, and used oxygen. The resident's care plan, dated March 7, 2024, revealed that staff were to administer oxygen as ordered by the physician.</p> <p>Observations on August 19, 2024, at 12:11 p.m. revealed that Resident 139 was receiving oxygen via nasal cannula (tube that delivers oxygen) set at a flow rate of 2.0 liters per minute.</p> <p>There was no documented evidence that a physician's order was received for the administration of oxygen.</p> <p>Interview with the Nursing Home Administrator on August 21, 2024, at 3:23 p.m. confirmed that there was no physician's order for Resident 139 to receive oxygen.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<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>19102</p> <p>Based on facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for three of 56 residents reviewed (Residents 36, 94, 116).</p> <p>Findings include:</p> <p>A facility policy for medication administration, dated June 1, 2024, indicated that the individual administering a medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 36, dated July 23, 2024, indicated that the resident was understood and able to understand others, required substantial to maximum assistance for his daily care needs, and had diagnoses that included dementia.</p> <p>Physician's orders for Resident 36, dated June 15, 2024, and July 17, 2024, included to administer 50 milligrams (mg) of Tramadol (a controlled medication use to treat pain) every eight hours as needed for right shoulder or right wrist pain.</p> <p>Review of the controlled drug administration records (tracks each dose of a controlled medication) for Resident 36, dated April 13, 2024, and June 25, 2024, indicated that 50 mg of Tramadol was signed out as administered on June 15, 2024, at 3:15 p.m.; June 18, 2024, at 1:30 p.m.; June 19, 2024, at 5:00 p.m.; and July 19, 2024, time unreadable.</p> <p>Review of the Medication Administration Records (MAR's) for Resident 36, dated June and July 2024, revealed no documented evidence that the signed-out doses of Tramadol were administered on the above-mentioned dates and times.</p> <p>Interview with the Director of Nursing on August 22, 2024, at 1:06 p.m. confirmed that there was no documented evidence that the signed-out doses of Tramadol were administered to Resident 36 on the above-mentioned dates and times.</p> <p>A quarterly MDS assessment for Resident 94, dated July 23, 2024, indicated that the resident was understood and able to understand others, required substantial to maximum assistance for his daily care needs, and had diagnoses that included dementia.</p> <p>Physician's orders for Resident 94, dated June 1, June 18, July 3, and July 17, 2024, included an order to administer 0.25 mL of 2 mg/ml of Ativan every six hours as needed for anxiety/shortness of breath.</p> <p>Review of the controlled drug administration records for Resident 94 for June and July 2024 revealed that 0.25 mL of 2 mg/ml of Ativan was signed out as administered on June 10 at 3:13 a.m., June 18 at 3:30 a.m., June 20 at 1:00 a.m., and July 3, 2024, at 10:00 p.m.</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>Review of the MAR's for Resident 94 for June and July 2024 revealed that there was no documented evidence the signed-out doses of Ativan were administered on the above-mentioned dates and times.</p> <p>Interview with the Director of Nursing on August 22, 2024, at 1:06 p.m. confirmed that there was no documented evidence the signed-out doses of Ativan for Resident 94 were administered on the above-mentioned dates and times.</p> <p>A quarterly MDS assessment for Resident 116, dated July 4, 2024, indicated that the resident was understood and able to understand others, was dependent on staff for daily care needs, and had diagnosis that included stroke.</p> <p>Physician's orders for Resident 116, dated July 31, 2024, included for the resident to receive 0.25 milliliters (ml) of Ativan 2mg/ml solution every six hours as needed for anxiety for 14 days.</p> <p>Review of the controlled drug administration records for Resident 116, dated August 4, 2024, indicated that 0.25 ml of Ativan 2 mg/ml solution was signed out as administered on August 13, 2024, no time recorded, and on August 14, 2024, at 8:00 p.m.</p> <p>Review of the MAR for Resident 116, dated August 2024, revealed no documented evidence that the signed-out doses of Ativan were administered on the above-mentioned dates and times.</p> <p>Interview with the Director of Nursing on August 22, 2024, at 1:06 p.m. confirmed that there was no documented evidence that the signed-out doses of Ativan were administered on the above-mentioned dates and times.</p> <p>28 Pa. Code 211.9(h) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>19102</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that it was free from significant medication errors for two of 56 residents reviewed (Residents 8, 56).</p> <p>Findings include:</p> <p>The facility's policy regarding medication administration, dated June 1, 2024, indicated that medications are administered in accordance with prescriber orders, including any required time frame.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated July 17, 2024, revealed that the resident was cognitively impaired, was dependent on staff for personal care needs, and had diagnosis that included diabetes.</p> <p>Nurse's note for Resident 8, dated August 16, 2024, indicated that a new physician's order was obtained to decrease the resident's Levemir (type of long-acting insulin used to lower blood sugar) to 33 units every day.</p> <p>Physician's orders for Resident 8, dated August 16, 2024, included an order to discontinue giving 35 units of Levemir insulin once a day.</p> <p>Physician's orders for Resident 8, dated August 16, 2024, included an order to administer 33 units of Toujeo SoloStar (long-acting insulin used to lower blood sugar) insulin once a day.</p> <p>Review of the Medication Administration Record (MAR) for Resident 8, dated August 2024, revealed no documented evidence that the resident received insulin on August 17, 18, 19, and 20, 2024.</p> <p>Interview with the Director of Nursing on August 20, 2024, at 5:09 p.m. revealed that there was a glitch in the pharmacy system and the previous insulin order was discontinued; however, the new insulin order was not processed resulting in the resident not getting insulin as ordered on August 17, 18, 19, and 20, 2024.</p> <p>A quarterly MDS assessment for Resident 56, dated June 18, 2024, revealed that the resident was cognitively intact, received insulin, and had diagnoses that included diabetes (a disease that interferes with blood sugar control).</p> <p>Physician's orders for Resident 56, dated January 10, 2023, included an order for the resident to receive 12 units of Humalog insulin subcutaneously (injected just under the skin) in the morning related to diabetes and to hold the insulin if the resident's blood sugar was less than or equal to 120 milligrams/deciliter (mg/dL), 20 units of Humalog insulin subcutaneously in the afternoon related to diabetes and to hold the insulin if the resident's blood sugar was less than or equal to 120 mg/dL, and 8 units of Humalog insulin subcutaneously in the evening related to diabetes and to hold the insulin if the resident's blood sugar was less than or equal to 120 mg/dL.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 56's Medication Administration Records (MAR's) for June, July and August 2024 revealed that at 9:00 a.m. on June 16 the resident's blood sugar was 116 mg/dL, on August 1 the resident's blood sugar was 115 mg/dL, on August 14 the resident's blood sugar was 105 mg/dL, and on August 19 the resident's blood sugar was 116 mg/dL; at 12:00 p.m. on August 12 the resident's blood sugar was 120 mg/dL and on August 14 the resident's blood sugar was 103 mg/dL; and at 5:00 p.m. on June 20 the resident's blood sugar was 117 mg/dL, on June 27 the resident's blood sugar was 114 mg/dL, on July 2 the resident's blood sugar was 90 mg/dL, on July 5 the resident's blood sugar was 104 mg/dL, on July 8 the resident's blood sugar was 117 mg/dL, on July 11 the resident's blood sugar was 117 mg/dL, on July 22 the resident's blood sugar was 118 mg/dL, on August 12 the resident's blood sugar was 120 mg/dL, and on August 20, 2024, the resident's blood sugar was 90 mg/dL.</p> <p>There was no documented evidence that the resident's insulin was held on the above dates as ordered by the physician.</p> <p>Interview with the Director of Nursing on August 22, 2024, at 2:52 p.m. confirmed that Resident 56's insulin was not held when the resident's blood sugar was less than or equal to 120 mg/dL on the dates mentioned above and should have been held.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>19102</p> <p>Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to label medications with the date they were opened in one of two medication rooms reviewed (A unit) and in two of four medication carts reviewed (A and B unit).</p> <p>Findings include:</p> <p>The facility's policy regarding medication storage/labeling, dated June 1, 2024, indicated that multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.</p> <p>An undated package insert for Tubersol (used to test for tuberculosis - a bacterial infection) revealed that once entered/opened, the vial was to be discarded after 30 days.</p> <p>Observations in the medication room refrigerator on the A unit on August 22, 2024, at 12:18 p.m. revealed that an opened vial of Tubersol was not properly labeled with the date it was opened.</p> <p>An interview with Registered Nurse 1 at that time confirmed that the opened vial of Tubersol was not properly labeled with the date it was opened and should have been.</p> <p>Manufacturer's instructions for Basaglar (insulin) pen, dated November 2023, revealed that the pen should be thrown away after 28 days of use, even if it still has insulin left in it.</p> <p>Manufacturer's instructions for Humalog (insulin) pen, dated August 2023, revealed that the pen should be thrown away after 28 days of use, even if it still has insulin left in it.</p> <p>Manufacturer's instructions for Lyumjev (insulin) pen, dated October 2022, revealed that the pen should be thrown away after 28 days of use, even if it still has insulin left in it.</p> <p>Observations of the North B cart revealed an open and undated Basaglar pen for Resident 93, an opened and undated Lumjev pen for Resident 58, and an opened and undated Humalog pen for Resident 58.</p> <p>Interview with Licensed Practical Nurse 4 on August 21, 2024, at 8:04 a.m. revealed that the Basaglar, Humalog, and Lyumjev pens were not dated when opened and that they should have been.</p> <p>Physician's orders for Resident 2, dated July 31, 2024, included orders for the resident to receive Lyumjev Kwikpen (insulin lispro- fact acting insulin) subcutaneously (beneath the skin) with meals based on a sliding scale (amount of insulin based on blood sugar results), and was to give 2 units of Lyumjev for a blood sugar of 150-200 milligrams per deciliter (mg/dL).</p> <p>Observations during the medication pass on August 21, 2024, at 7:49 a.m. revealed that Licensed Practical Nurse 5 administered 2 units of Lyumjev to Resident 2 for a blood sugar result of 180 mg/dL and the Lyumjev Kwikpen was not dated when opened.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Licensed Practical Nurse 5 at that time confirmed that the Lyumjev Kwikpen was not dated when opened and should have been.</p> <p>Interview with the Director of Nursing on August 21, 2024, at 10:38 a.m. confirmed that the insulin pens should have been dated when opened.</p> <p>28 Pa. Code 211.12(d)(1) Nursing Services.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>19102</p> <p>Based on observations and interviews with residents and staff, it was determined that the facility failed to serve food that was palatable to residents.</p> <p>Findings include:</p> <p>Interviews on August 19, 2024, with Resident 28 at 12:17 p.m. and Resident 56 at 12:22 p.m. revealed that the food was terrible and a little rough.</p> <p>The posted menu for August 20, 2024, revealed that the lunch meal was chicken teriyaki, fluffy steamed rice, seasoned broccoli, and sherbet.</p> <p>Observations in the kitchen on August 20, 2024, at 11:57 p.m. revealed that a test tray was placed on the lunch meal cart going to the A wing. The cart arrived on the unit at 11:59 p.m., and the last resident was served and eating at 12:15 p.m. At 12:15 p.m. the temperature of the chicken teriyaki was 131.7 degrees Fahrenheit (F) and was dry, and the temperature of the seasoned broccoli was 134.7 degrees F and it was mushy.</p> <p>Interview with the Dietary Manager on August 20, 2024, at 12:15 p.m. confirmed that the chicken appeared dry and the broccoli was mushy and over-cooked.</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>19102</p> <p>Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that food was stored and served in accordance with professional standards for food service safety and failed to effectively sanitize dishes during mechanical dishwashing.</p> <p>Findings include:</p> <p>The facility's policy for food storage, dated June 1, 2024, revealed that leftover food was to be stored in covered containers or wrapped carefully and securely, and each item was to be clearly labeled and dated before being refrigerated.</p> <p>Observations of the walk-in refrigerator and dry storage area on August 19, 2024, at 8:45 a.m. revealed that there were two Styrofoam containers that contained cooked eggs/omelets that were not dated or labeled, and one gallon of corn syrup that was open without a lid.</p> <p>Interview with the Dietary Manager on August 19, 2024, at 8:45 a.m. confirmed that staff should have labeled and dated the Styrofoam containers of eggs and she was not sure why there was no lid on the gallon of corn syrup in the dry storage area.</p> <p>Observations in the main kitchen on August 19, 2024, at 8:45 a.m. and August 21, 2024, at 1:17 p.m. revealed that there was a fan on top of the ice machine that had dust accumulation on the blades and cage and was blowing towards the food prep/service area, and 51 one clear cups had a white, removable residue on the inside of them.</p> <p>The facility's policy regarding pot and pan washing, dated June 1, 2024, indicated that pots and pans were to be sanitized in the third sink using warm water and bleach or sanitizer to provide no less than 50 parts per million (PPM) chlorine in solution for one minute.</p> <p>Observations on August 21, 2024, at 1:30 p.m. revealed that Dietary Aide 6 was washing metal pans and scoops using the three-compartment sink. She washed and rinsed the pans and scoops in the first and second sinks and then placed them in the third sink to sanitize, removing them in a couple seconds.</p> <p>Interview with the Dietary Manager on August 21, 2024, at 1:25 p.m. and 1:44 p.m. confirmed that the fan was dirty and needed cleaned, the clear cups had a build up of white residue in them, and that Dietary Aide 6 should have left the items soak in the sanitizing solution for a longer period of time.</p> <p>28 Pa. Code 211.6(f) Dietary Services.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19102</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents' clinical records were complete and accurately documented for three of 56 residents reviewed (Residents 94, 98, 112).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 94, dated July 10, 2024, revealed that the resident could usually make herself understood and understand others, was cognitively impaired, and had diagnoses that included dementia and a stroke.</p> <p>Nurse aide documentation for Resident 94 for June, July and August 2024 revealed that staff were documenting every shift that the resident was wearing a wander bracelet (alarming device) June 14 through August 20, 2024.</p> <p>Observations of Resident 94 on August 20, 2024, at 11:06 a.m. revealed that the resident was sitting in her wheelchair and did not have a wander bracelet (alarming device) on.</p> <p>Interview with Registered Nurse 1 on August 20, 2024, at 11:06 a.m. confirmed that Resident 94 did not have a wander bracelet on and staff were charting that one was in place.</p> <p>A quarterly MDS for Resident 98, dated May 9, 2024, revealed that he was confused, required minimal staff assistance with his daily care needs, and was admitted to the facility on [DATE]. A nursing note, dated June 26, 2024, indicated that the resident was not confused and was able to make his own decisions.</p> <p>A consultation with an orthopedic surgeon for Resident 98, dated August 2022, revealed that the resident required both knees to be replaced; however, he was homeless, had teeth that needed extracted, and needed to detox from alcohol before he was considered for surgery.</p> <p>A Certified Registered Nurse Practitioner's (CRNP - advanced practice nurse) note, dated March 21, 2024, revealed that Resident 98 was homeless and that he required all of his teeth to be extracted prior to having his knee replacement surgeries. He was admitted to the facility in order to have his teeth extractions, a consult with a gastrointestinal (GI) doctor related to his alcoholism, and so that he would have somewhere to discharge to after his knee replacements. The physician further noted that the resident had an addiction to narcotics and was not taking his medications appropriately while homeless.</p> <p>A nurse's note, dated April 1, 2024, revealed that Resident 98 was to consult an oral surgeon for teeth extractions on April 4, 2024, and that he was to have a consult with the GI doctor on April 5, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A physician's note, dated April 11, 2024, indicated that Resident 98 saw the GI doctor on April 9, 2024, and was to have a procedure done in order for them to clear him for any surgery.</p> <p>A nurse's note, dated June 14, 2024, indicated that Resident 98 was seen by the oral surgeon and that there were no new orders.</p> <p>A CRNP note for Resident 98, dated June 20, 2024, revealed that the resident was to have a GI procedure on July 11, 2024.</p> <p>A note, authored by the Nursing Home Administrator on July 8, 2024, for Resident 98 indicated that the resident wanted permission to use the local transit bus to go to appointments and stores as well as the bank, and he was angry because this was not an approved method of transport due to him needing to have supervision on his outings.</p> <p>A social services note, dated July 29, 2024, revealed that the resident was issued a 30-day eviction notice because he failed to pay his bill.</p> <p>Interview with Resident 98 on August 19, 2024, at 1:19 p.m. revealed that he was issued an eviction notice for non-payment. He stated that he did not authorize the facility take his Social Security or any money out of his bank account and as soon as he found out that they had taken payment for the month of June, he went to the bank and stopped payment. He also called the Social Security office and had that stopped as well. He stated that other residents live in the home for free and he refused to give the nursing home a dime. He said that he did not care for the way the nursing home was run, that staff did not have to do anything for him, and that he did not feel that he should have to pay anything. He was angry because the administrative staff would not allow him to live at the home for free, travel anywhere he wanted to go on the transit bus, and that his brother was able to sign him in to the nursing home. He stated that he agreed to go to the nursing home so that he could have all his teeth extracted and see a doctor so that he could have his knees replaced. He said that he was not going to pay the nursing facility because they did not do their job in getting those things done for him.</p> <p>During interview with Resident 98 on August 21, 2024, at 4:32 p.m. he again stated he was not going to pay the nursing home at all and he would not permit them to take his income so that he could live at the nursing home. He said that he obtained a lawyer that was willing to sue the nursing home so that the resident would not have to pay them for having lived there. He also stated that the Nursing Home Administrator was planning to pay for one week's rent at the motel when he is evicted from the nursing home on August 29; however, he wanted the cash handed to him because he had a better idea for the money. He believed he could get an apartment and pay for the month's rent with the money. He also talked about squatter's rights, which he had been informed of by an attorney. He said that he really wanted to be discharged out of the nursing home but that he was not permitted back into the majority of the homeless shelters or the Salvation Army.</p> <p>(continued on next page)</p>

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 08/22/2024
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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Social Services Director and the Director of Nursing on August 22, 2024, at 10:52 a.m. revealed that Resident 98 was scheduled for teeth extraction; however, he cancelled it. He did not tell anyone at the facility that he cancelled it. He would not allow the staff to reschedule the appointment. She stated that he further cancelled his GI appointments and would not allow the staff to help him reschedule them either. She stated that the resident insisted he wanted all of his teeth pulled at one time and that he also wanted dentures made at that time, and there was no oral surgeon that would remove a mouth full of teeth and provide them with dentures that same day.</p> <p>An interview with the Social Services Director on August 22, 2024, revealed that she was aware that the resident was canceling his own appointments, not rescheduling them, attempting to arrange transport with a city transit bus, and that he was not willing to let the facility assist him in making his appointments. She said that Resident 98's medical record was not complete as it did not contain any of that information and it should have.</p> <p>A quarterly MDS for Resident 112, dated July 19, 2024, revealed that she was severely cognitively impaired and required staff assistance with her daily care needs. A speech therapy note, dated July 27, 2024, indicated that the resident had a choking episode and required the Heimlich maneuver on July 26, 2024.</p> <p>There was no documentation in Resident 112's medical record indicating that the resident had choked or that she required the Heimlich maneuver.</p> <p>Interview with the Director of Nursing on August 20, 2024, at 12:28 p.m. revealed that Resident 112's clinical record did not contain any information regarding the choking episode and it should have.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p> <p>28 Pa. Code 211.12(d)(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>19102</p> <p>Based on review of established infection control guidelines, facility policy, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for three of 56 residents reviewed (Residents 25, 77, 94).</p> <p>Findings include:</p> <p>CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply.</p> <p>The facility's policy regarding Enhanced Barrier Precautions (EBP), dated June 1, 2024, indicated that precautions are used as an infection prevention and control intervention to reduce the spread for multi-drug resistant organisms (MDRO's) to residents. EBP's are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. EBP's remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 25, dated July 18, 2024, revealed that the resident was understood and able to understand others, was dependent on staff for personal hygiene care, had an indwelling catheter (a small tube inserted into the bladder to drain urine), and had diagnosis that included renal insufficiency.</p> <p>Physician's orders, dated July 20, 2024, included for the resident to have a 16 French (indicates a size) foley catheter (type of an indwelling catheter).</p> <p>Observations of Resident 25 on August 20, 2024, at 10:25 p.m. revealed that the resident was lying in bed with a urinary drainage bag hanging on the left side of her bed. There was no sign posted on her door or wall alerting staff and visitors of the resident's need for EBP.</p> <p>(continued on next page)</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>A significant change MDS assessment for Resident 77, dated August 6, 2024, revealed that the resident was cognitively intact and had a nephrostomy (procedure that creates an artificial opening in the skin and kidney to allow urine to drain from the kidney).</p> <p>Physician's orders, dated July 2, 2024, included an order for the resident to have her nephrostomy site cleaned with normal saline (solution of water and salt) and gauze applied every day shift. A care plan, dated July 12, 2024, indicated that the resident was to use nephrostomy tubes related to kidney stones.</p> <p>Observations on August 20, 2024, at 12:52 p.m. revealed that there was no sign posted on her door or wall alerting staff and visitors of the resident's need for EBP.</p> <p>A quarterly MDS assessment for Resident 94, dated July 10, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included dementia and a stroke.</p> <p>A wound note, dated August 13, 2024, revealed that Resident 94 had a vascular wound (wound caused by poor circulation) on her left foot.</p> <p>Physician's orders, dated August 13, 2024, included orders for the resident's left foot be cleaned with normal saline, Medi-Honey (honey based wound treatment) and Calcium Alginate with Silver (absorbent dressing used to prevent infection) applied, and covered with a dry dressing every day.</p> <p>Observations of Resident 94 during a dressing change on August 20, 2024, at 11:34 a.m. revealed that the resident had a vascular wound on her left foot. There was no sign posted on her door or wall alerting staff and visitors of the resident's need for EBP.</p> <p>Interview with the Director of Nursing on August 20, 2024, at 12:47 p.m. confirmed that Resident 25, 77, and 94 did require EBP because of their indwelling catheter, nephrostomy, and vascular wound and that a sign should have been posted on their door alerting staff to this; however, a sign was never posted.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		