

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2024
NAME OF PROVIDER OR SUPPLIER  Premier at Perry Village for Nursing and Rehab, LL		STREET ADDRESS, CITY, STATE, ZIP CODE 213 East Main Street New Bloomfield, PA 17068	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46253</p> <p>Based on facility job description, clinical record review, review of facility investigation and documentation, and staff interviews, it was determined that the facility displayed past non-compliance in its failure to provide adequate supervision and assistive devices to prevent accidents, which resulted in harm, as evidenced by a scalp laceration and a leg injury for one of two residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>Review of the facility's job description for a Transportation Driver, revealed [in part] must have knowledge of equipment used in long term care; and transports residents safely.</p> <p>Review of Employee 1's personnel file revealed that they were hired to be the Transportation Driver on January 30, 2024. Employee 1 signed the job description on January 30, 2024, and completed the self-evaluation portion of the job description. It was noted under section titled Specific Job Functions, Employee 1 had checked the self-evaluation column for Transports residents safely and in a timely manner to all appointments. The column on the job description titled Competency Testing Needed was noted to be blank.</p> <p>Further review of Employee 1's personnel file failed to reveal any education or competencies for equipment use or transportation safety measures to follow prior to April 25, 2024.</p> <p>Review of Resident 1's clinical record revealed diagnoses that included Alzheimer's disease (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), unspecified lack of coordination, and generalized muscle weakness.</p> <p>Review of Resident 1's clinical record revealed a progress note dated April 23, 2024, at 9:15 AM, that indicated [in part] This RN called to facility van to assess resident after fall from litter chair while in van. Assessment was completed .Resident back to litter chair and returned to facility. Assessment completed with laceration to right side of head (12cm-centimeters) and edematous [swollen] left knee. MD notified, see new orders to send resident to ED [Emergency Department] for evaluation and treatment. RP [Responsible Party] made aware of fall, injury and hospital transport.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's hospital records dated April 23, 2024, revealed Resident 1 had a scalp laceration that measured 3 centimeters long and 5 centimeters deep which was repaired with adhesive and a fracture of the distal femur (large bone located in the upper leg) with regions of periosteal reaction (a non-specific x-ray finding that indicates new bone formation in reaction to abnormal stimulants) which may represent a chronic fracture; lucency (transparency-ability to see through) along the proximal tibia (small bone located in the lower leg) with regions of sclerosis (hardening) that may represent a chronic fracture; and moderate knee effusion with diffuse (scattered) soft tissue edema (swelling). X-ray report indicated that it was compared to an x-ray report from October 8, 2010. It was also noted that the report indicated further studies should be considered.</p> <p>Resident 1 returned to the facility on [DATE], at 9:00 PM, with orders that included a left knee brace to be worn at all times expect for bed bath and bed rest for two months.</p> <p>Further review of Resident 1's clinical record failed to reveal any documentation of swelling to the left knee prior to the incident or that Resident 1 had a history of a left femur or tibia fracture.</p> <p>During an interview with the Nursing Home Administrator (NHA) on May 8, 2024, at 11:40 AM, the NHA indicated that nurse aides put Resident 1 on the litter chair and covered the Resident with a blanket in preparation for the transport to an appointment. Employee 1 (transportation driver) proceeded to load the Resident into the facility transport van. The NHA said that when Employee 1 turned the first curve in the parking lot, Resident 1 rolled off the litter chair and Employee 1 stopped immediately and called for assistance. The NHA indicated that she was among the staff that responded to the call for assistance. The NHA said that the litter chair was secured to the vehicle, the small rails on the litter chair were in the upright position, but the safety belt on the litter chair had not been strapped around Resident 1. She also confirmed that Employee 1 told her that the Resident was not checked to make sure Resident 1 was secured onto the litter chair. Employee 1 indicated to the NHA that she did not see the belt hanging from under the covers so she assumed it was buckled. NHA said that 911 was called and Resident 1 was transported to the hospital. NHA indicated that they have had no other litter chair transports since this incident occurred. She said that they do not use the litter chair very often as most all residents can be transported in a regular wheelchair.</p> <p>Review of the facility investigation revealed a witness statement from Employee 1 that stated that Resident 1 was wheeled to the back door and given to them to place into the van. Employee 1 indicated that they secured the litter chair into the lift and that once inside the van they secured the litter chair with the two front and two rear tension belts and put all four brakes on the litter chair. Employee 1 indicated that she pulled back and forth on the litter chair to ensure the litter chair did not move. Employee 1 then said that as she was turning out of the parking lot, she heard a noise and looked back and noted that Resident 1 was not on the litter chair. Resident 1 had fallen sideways off the litter chair. Employee 1 indicated that she stopped the van and called the facility immediately for assistance. Employee 1 indicated that after the fall, she realized that the seat belt for the litter chair was found stuck under the adjustable head section of the litter chair. Employee 1 also indicated that Resident 1 had two blankets on when she received her from nursing staff and that she could not see if the seat belt on the litter chair was on but that the seat belt was not visualized to be hanging down.</p> <p>Further review of facility investigation revealed a witness statement from Employee 2 (Nurse Aide) that indicated that they got Resident 1 on the litter chair for an appointment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an ongoing interview with the NHA on May 8, 2024, at approximately 11:50 AM, the NHA indicated that after the incident occurred with Resident 1 she reviewed Employee 1's personnel file and found no competency completed for the use of the litter chair. The NHA further indicated that she also checked the files for the back-up drivers as well and found that they had no competency completed either. She said that she then arranged for the company's transportation hub director to come to facility and complete training and competency with all of the facility drivers. The NHA also stated that she could not find a written procedure/process for staff to follow for the use of the litter chair. The NHA stated that the facility also completed education with nursing staff regarding the proper process to follow for the use of the litter chair.</p> <p>Review of facility provided documentation revealed that they had developed a Four Point Plan to correct the identified issue. This plan was as follows: 1) Cannot correct the past occurrence; resident evaluated and being treated for laceration and fracture; 2) Residents being transported from facility to outside appointments will be secured appropriately; 3) Education was completed with nursing staff on securing residents to the litter chair and with transportation driver on second verification that residents are secured to the litter chair. Staff who are able to drive transport van will be educated and provided competency on transportation of residents via litter chair; and 4) The facility will be in substantial compliance by April 25, 2024.</p> <p>Review of facility provided documentation revealed that the Transportation Drivers, Employees 1, 3, and 4, received training and completed a competency on April 25, 2024.</p> <p>Review of the education sign in sheet revealed that Employee 2 signed the form on April 23, 2024 confirming education was received.</p> <p>Review of facility provided documentation revealed that On-the-Spot education was completed with nursing staff regarding the litter chair and proper procedures. The On-the-Spot sign in sheet had 35 nursing staff signatures which included Registered Nurses, Licensed Practical Nurses, and Nurse Aides. The education indicated the following: 1) Seat belt on litter chair should be securely strapped and buckled; 2) Seat belt should be buckled over any blankets that are in place; 3) TWO staff members should ensure that resident is securely strapped in litter chair prior to loading resident in van; and 4) Both siderails on litter chair should be engaged/raised prior to loading resident in van.</p> <p>During an interview with the NHA and Employee 3 on May 8, 2024, at 1:45 PM, Employee 3 indicated that they were the back-up transportation driver. They indicated that they had been employed at the facility since 2003, and that they had received training back when the facility obtained the van. Employee 3 confirmed that they received training after the recent incident and was able to recall steps in the process such as double checking that the resident is secured on the litter chair, how to load and unload the litter chair, and properly securing the litter chair into the vehicle.</p> <p>During an interview with Employee 4 on May 8, 2024, at 1:54 PM, Employee 4 indicated that they are the primary back-up driver. Employee 4 confirmed that they had received training after the incident occurred and indicated that the training included securing resident to the litter chair, safely loading and unloading the resident on the litter chair into and from the van, and how to secure the litter chair in the van.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Employee 7 (Nurse Aide) on May 8, 2024, at 2:45 PM, indicated that they received training right after the incident happened. Employee 7 indicated that they only work two days a week and had never used the litter chair</p> <p>During a final interview with the NHA on May 8, 2024, at 3:00 PM, she indicated that Resident 1's RP did not want any further testing completed. She confirmed that Resident 1 was not properly secured the resident to the litter chair and that the transport driver failed to ensure that the resident was properly secured to the litter chair prior to pulling out for the transport. She confirmed that these actions resulted in actual harm to Resident 1. She indicated that the facility identified the issue, established a process to follow, and completed education and competencies on the process. She again confirmed that they had not had any other litter chair transports since this incident occurred.</p> <p>During the abbreviated survey, staff education and competencies were reviewed. Staff interviews, Resident record reviews and observations revealed no concerns with the safety of transportation of residents.</p> <p>201.4(a) Responsibility of Licensee.</p> <p>201.18(b)(1) Management.</p> <p>201.20(b) Staff Development.</p> <p>211.10(d) Resident Care Policies.</p> <p>211.12(d)(1)(2)(3) Nursing Services.</p>		