

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>46253</p> <p>Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to determine a resident's right to self-administer medications was clinically appropriate for one of one resident reviewed (Resident 3).</p> <p>Findings include:</p> <p>Review of facility policy, titled Self-Administration of Medications, with a last revised date of December 2016, revealed the following, in part: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so; 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident; 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) a. ability to read and understand labels, b. comprehension of the purpose and proper dosage and administration time for his or her medications, c. ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication, and d. the ability to recognize risks and major adverse consequences of his or her medication.</p> <p>Review of Resident 3's clinical record revealed diagnoses that included hypertension (high blood pressure), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and osteoarthritis (degeneration of joint cartilage and the underlying bone, causing pain and stiffness especially in the hip, knee, and thumb joints).</p> <p>Review of Resident 3's physician orders revealed an order for Voltaren (Diclofenac Sodium Topical) Arthritis Pain External Gel 1% Apply to joints topically every 6 hours as needed for pain. Resident administers self (medication at bedside), dated June 21, 2024.</p> <p>Review of Resident 3's clinical record failed to reveal an assessment for self-administration of medications.</p> <p>During an interview with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Employee 8 Regional Director of Clinical Services (RDCS) on July 10, 2024, at 1:12 PM, Resident 3's medication self-administration order and lack of documented self-administration medication assessment was discussed for further follow-up.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A follow-up review of Resident 3's clinical record revealed a nurse's note dated July 11, 2024, at 2:08 AM, that indicated the nurse had Discussed pt [patient] voltaren gel, and other medicated creams which [the Resident was] keeping in [their] drawer and whether [the Resident] would like to self-administer those creams. if so we could complete the self admin assessment. Pt states,[the Resident has] nursing apply the creams and as long as they are applied when [the Resident] ask it's fine to keep them in the treatment cart. All creams removed and placed in the nursing treatment cart.</p> <p>During a final interview with the NHA, DON, and Employee 8 RDCS, on July 11, 2024, at 11:05 AM, Employee 8 RDCS indicated that when they spoke to Resident 3 regarding self-administering of medications, the Resident indicated that they did not wish to do so and all meds were removed. Employee 8 RDCS further indicated that she was not sure why the nurse had put the order in that way if the Resident did not want to self-administer. Employee 8 RDCS confirmed that no self-administration of medications assessment had been completed and that the medications should not have been left at the bedside.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident Care Policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>37013</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident or their representative received written notice of the facility bed-hold policy at the time of transfer for one of nine residents reviewed (Resident 9), and failed to ensure that the written notice of the facility bed-hold policy at the time of transfer included the reserve payment required for four of nine residents (Residents 3, 4, 9, and 136).</p> <p>Findings Include:</p> <p>Review of Resident 3's clinical record revealed diagnoses that included hypertension (high blood pressure), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).</p> <p>Further review of Resident 3's clinical record revealed that on May 29, 2024, the Resident was transferred out of the facility to the hospital and was subsequently admitted to the hospital.</p> <p>Review of Resident 3's bed-hold policy notice provided to the Resident at the time of their hospital transfer indicated that a bed would be held for them for 15 days according to Medicaid regulations at no cost to Resident 3. In addition, a Bedhold Reservation Request was attached but failed to include the bed reservation cost.</p> <p>Further review of Resident 3's clinical record census tab failed to identify Medicaid as their payer source at the time of their hospital transfer.</p> <p>Review of Resident 4's clinical record revealed diagnoses that included intellectual disability (neuro-developmental condition that limits a person's cognitive function and skills), Aphasia (language disorder that affects a person's ability to communicate, and epilepsy (disorder in which nerve cell activity in the brain is disturbed causing seizures).</p> <p>Further review of Resident 4's clinical record revealed that on April 25th, May 15th, and June 3rd, 2024, the Resident was transferred out of the facility to the hospital and was subsequently admitted to the hospital.</p> <p>Review of Resident 4's bed-hold policy notice provided to the Resident Representative at the time of their hospital transfers indicated that a bed would be held for them for 15 days according to Medicaid regulations at no cost to Resident 4. In addition, a Bedhold Reservation Request was attached but failed to include the bed reservation cost.</p> <p>Review of Resident 9's clinical record revealed diagnoses that included end stage renal disease (ESRD-a condition in which the kidneys lose the ability to remove waste and balance fluids) and atrial fibrillation (AFib- a irregular, often rapid heart rate that commonly causes poor blood flow).</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident 9's clinical record revealed that she was transferred and admitted to the hospital on June 21, 2024.</p> <p>During an interview with the Nursing Home Administrator on July 11, 2024, at 2:06 PM, she stated that the bed-hold notice was not provided to Resident 9 or her Responsible Party at the time of her hospital transfer.</p> <p>Review of Resident 136's clinical record revealed diagnoses that included retention of urine, migraine (headache of varying intensity often accompanied by nausea and sensitivity to light and sound), cerebral infarction (stroke- as a result of disputed blood flow to the brain due to problems with the blood vessels that supply it), calculus in bladder and kidney (a small hard deposit of minerals and acid salts that stick together in concentrated urine), hemiplegia left non-dominant side (paralysis on one side of the body), and mild cognitive impairment (a condition that causes people to have more memory or thinking problems that others their age).</p> <p>Further review of Resident 136's clinical record revealed that on March 14th and 25th, 2024, the Resident was transferred out of the facility to the hospital and was subsequently admitted to the hospital.</p> <p>Review of Resident 136's bed-hold policy notice provided to the Resident at the time of their hospital transfers indicated that a bed would be held for them for 15 days according to Medicaid regulations at no cost to Resident 4. In addition, a Bedhold Reservation Request was attached but failed to include the bed reservation cost.</p> <p>During an interview with the NHA, Director of Nursing, and Employee 8 (Regional Director of Clinical Services) on July 11, 2024, at 11:07 AM, the NHA indicated that she had no additional information to provide. She said that nursing staff generates the bed-hold notice at the time of a resident transfer, and they would not be aware of room rates. She said that the Business Office Manager would speak to individuals with questions. She further indicated that she could not confirm that all residents or their responsible parties were made aware of bed-hold reserve payments and that the facility would review its process and make appropriate changes.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>48484</p> <p>Based on facility policy review, record review, and resident and staff interviews, it was determined that the facility failed to ensure the resident's right to participate in the care planning process, and failed to review and revise the resident plan of care for two of 31 resident's reviewed (Residents 10 and 125).</p> <p>Findings include:</p> <p>Review of facility policy, titled Care Plans, Comprehensive and Person-Centered, last revised September 2022, read, in part, 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 resident. Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care including the right to participate in the planning process and request meetings. The care planning process will facilitate resident and/or representative involvement. Assessments of residents are ongoing and care plans are revised as information about the resident and residents' conditions change.</p> <p>Review of Resident 10's clinical record revealed diagnoses that included left hand contracture (a permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult), chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), and muscle weakness.</p> <p>Interview with Resident 10 on July 8, 2024, at 10:33 AM, revealed she does not remember getting invited to her care plan meetings.</p> <p>Review of Resident 10's clinical record revealed an annual care plan meeting note dated November 11, 2023; and two quarterly care plan meeting notes dated February 20, 2024, and May 21, 2024. Review of the care plan meeting notes failed to reveal the Resident or her Representative attended the meetings.</p> <p>Further review of Resident 10's clinical record failed to reveal notation she was invited to any of the aforementioned care plan meetings.</p> <p>Review of select facility documentation provided revealed Resident 10's Representative was invited to attend the care plan meeting held in May 2024 via letter.</p> <p>Review of Resident 125's clinical record revealed diagnoses that included muscle weakness, feeding difficulties, and COPD.</p> <p>Interview with Resident 125 on July 8, 2024, at 10:39 AM, revealed he has not been invited to his care plan meetings.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 125's clinical record revealed three quarterly care plan meeting notes dated December 26, 2023, February 28, 2024, and May 28, 2024. Review of the care plan meeting notes failed to reveal the Resident or his Representative attended the meetings.</p> <p>Further review of Resident 125's clinical record failed to reveal notation he was invited to any of the aforementioned care plan meetings.</p> <p>Review of select facility documentation provided revealed Resident 125's Representative was invited to attend the care plan meeting held in May 2024 via letter.</p> <p>Interview with the Nursing Home Administrator (NHA) on July 10, 2024, at 1:36 PM, revealed Employee 4 (Social Worker) is responsible for coordinating the care plan meetings and sends a letter to resident representatives, however, she is not sure how the meetings are communicated to the residents themselves.</p> <p>Follow-up interview with the NHA, in the presence of Employee 8 (Regional Director of Clinical Services), on July 11, 2024, at 10:47 AM, revealed she is unable to locate any documentation to indicate that Residents 10 or 125 were invited to their care plan meetings.</p> <p>During an interview with Employee 8 on July 11, 2024, at 10:48 AM, she confirmed they don't have evidence Residents 10 or 125 were invited to their care plan meetings. She revealed the misstep in their process is that Employee 4 sends a letter to resident representatives or, if residents are their own representative, she will address the letter to the resident; however, residents who are not their own representative are not getting a letter, and they should be invited to their care plans regardless if they have a representative. She further revealed they are going to adjust their process to make sure residents are invited to their care plan meetings.</p> <p>Review of Resident 125's physician orders revealed an order for plastic utensils for all meals, with a start date of December 13, 2023.</p> <p>Email correspondence with the NHA on July 9, 2024, at 11:42 AM, the surveyor requested information about Resident 125's need for plastic utensils at meals.</p> <p>Review of an occupational therapy progress report from December 11, 2023, revealed a comment under objective progress for eating that stated improving with plastic utensils.</p> <p>Review of select facility documentation provided revealed a therapy treatment encounter note from December 13, 2023, that stated Patient setup for self-feeding. Patient demonstrated improved ability to perform task with lightweight items. Small plastic cups and plastic utensils increase independence due to lightweight and ease to grab due to poor fine motor skills on bilateral hands.</p> <p>Interview with the NHA on July 10, 2024, at 1:33 PM, revealed she would expect Resident 125's care plan to be updated to reflect the use of plastic utensils at meals for self-feeding ability.</p> <p>28 Pa. Code 211.10(d)(a) Resident care policies</p> <p>28 Pa. Code 211.11(d)(3)(5) Nursing services</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37817</b></p> <p>Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards for two of 31 residents reviewed (Residents 10 and 136).</p> <p>Findings include:</p> <p>Review of Resident 10's clinical record revealed diagnoses that included atrial fibrillation (a disease of the heart characterized by irregular and often faster heartbeat), chronic obstructive pulmonary disease (COPD - a group of lung disease that block airflow and make it difficult to breathe), and muscle weakness.</p> <p>Review of Resident 10's physician orders revealed an order for Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 mg (milligrams- unit of measure) Give 25 mg by mouth one time a day, with a start date of February 23, 2022, that was discontinued January 8, 2024.</p> <p>Further review of Resident 10's physician orders revealed an active order for Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 mg, Give 25 mg by mouth one time a day, hold for systolic blood pressure less than 100, with a start date of January 9, 2024.</p> <p>Review of Resident 10's clinical record revealed a pharmacy recommendation from December 21, 2023, to ensure blood pressure measurements are taken prior to metoprolol administration. The recommendation was signed by the physician on January 8, 2024, and the metoprolol order was updated on January 9, 2024, to include the directions to hold the medication if the Resident's systolic blood pressure is less than 100.</p> <p>Review of Resident 10's clinical record failed to reveal blood pressure measurements during the month of January 2024.</p> <p>Review of Resident 10's clinical record revealed a pharmacy recommendation from January 26, 2024, again recommending blood pressure measurements to be taken prior to metoprolol administration, the recommendation was signed by the physician on February 5, 2024.</p> <p>Review of Resident 10's MAR (Medication Administration Record- documentation for medication/treatment administered or monitored), revealed the metoprolol medication was documented as administered with a systolic blood pressure less than 100 on February 6, 2024; April 21, 2024; and May 5, 2024.</p> <p>During an interview with Employee 8 (Regional Director of Clinical Services) in the presence of the Director of Nursing (DON) on July 11, 2024, at 10:52 AM, she revealed the pharmacy recommendation was not implemented until the second recommendation was made and signed by the physician on February 5, 2024, due to a transcription error when the order was entered on January 9, 2024, that did not prompt nursing staff to take blood pressures on the MAR.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the DON on July 11, 2024, at 10:54 AM, revealed she would expect physician orders to be entered properly and followed. She further revealed she would expect medications not to be administered outside of the directed parameters.</p> <p>Review of Resident 136's clinical record revealed diagnoses that included retention of urine, migraine (headache of varying intensity often accompanied by nausea and sensitivity to light and sound), cerebral infarction (stroke- as a result of disputed blood flow to the brain due to problems with the blood vessels that supply it), calculus in bladder and kidney (a small hard deposit of minerals and acid salts that stick together in concentrated urine), hemiplegia left non-dominant side (paralysis on one side of the body), and mild cognitive impairment (a condition that causes people to have more memory or thinking problems that others their age).</p> <p>During an interview with Resident 136 on July 8, 2024, at 10:35 AM, it was revealed that, upon return from a urology appointment, he was to have blood work and a urine test, and the tests were never completed. It was revealed that, upon return from the hospital, he went several days without receiving pain medication that he received prior to his hospitalization .</p> <p>Review of Resident 136's progress notes dated March 12, 2024, read, in part, the foley catheter draining dark yellow urine. Resident complained of not feeling well and physician was made aware while in the building and assessed resident. Physician ordered Complete Blood Count with differential (CBC with diff- blood test that measures the number of different types of white blood cells, as well as red blood cells and platelets), Urinalysis and Culture and Sensitivity (UA C&amp;S- urine culture test to identify bacteria or yeast causing a urinary tract infection and an antibiotic sensitivity test), and the urine sample was obtained.</p> <p>Review of progress note dated March 13, 2024, revealed new orders for labs including UA C&amp;S, CBC with Diff, and Basic Metabolic Panel (BMP- blood test measures eight substances in the blood to assess how well the body is functioning).</p> <p>Review of progress notes dated March 14, 2024, at 6:05 AM, read, in part, urine output this shift 250 cubic centimeter (measure of volume) dark amber urine, Resident had UA C&amp;S collected yesterday, lab to pick up.</p> <p>Additional documentation at 8:30 AM read, in part, Resident with abdominal pain, tender to palpitation in his left lower quadrant and left [NAME] region. Resident complained of intermittent nausea. Discussed changing the location of the anchor for the catheter for better gravity drainage. Physician was informed and new orders to send Resident to emergency room for evaluation.</p> <p>Review of progress note at 7:21 PM, read, in part, Resident admitted with suspicious nodule on lung, rule out possible emboli (blood clot, air bubble or fatty deposit or other object which has been carried in the bloodstream to lodge in a blood vessel) right arm and urinary tract infection.</p> <p>Review of Resident 136's March 2024, physician orders failed to include orders for UA C&amp;S, CBC with Diff, and Basic Metabolic Panel.</p> <p>During interview with Employee 8 it was revealed that the labs for Resident 136 were never obtained due to the order incorrectly entered into the electronic health record and the Resident went out to the hospital on March 15, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 136 May 2024, Medication Administration Record revealed prior to Resident being transferred to the hospital on May 25, 2024, there was an as needed order for Tramadol every 8 hours for severe pain, and the order was discontinued on May 31, 2024.</p> <p>Review of hospital discharge instructions dated May 31, 2024, recommended Tramadol every 4 hours for pain; and an order for as needed oxycodone every 6 hours for pain.</p> <p>Review of Resident 136's May and June 2024, Medication Administration Record (MAR) failed to reveal an active order for Tramadol as of May 31st.</p> <p>Review of the May 2024 MAR the order for oxycodone every 6 hours for pain started May 31, 2024.</p> <p>Review of the June 2024 MAR the order for acetaminophen for mild pain was initiated June 1, 2024.</p> <p>Review of Resident 136's June 2024, MAR pain monitoring every shift revealed: June 1, 2024, evening shift a pain level of 1, and night shift a pain level of 1; June 2, 2024, evening shift a pain level of 5, and night shift a pain level of 2.</p> <p>Further review of Resident 136's June 2024 MAR revealed the following as needed pain medication was administered: acetaminophen for mild pain was administered on June 1, 2024, for a pain level 5 at 2:14 PM; June 2, 2024, for a pain level of 5 at 9:54 PM; June 3, 2024, for a pain level 7 at 1:04 PM. The order for acetaminophen didn't quantify a numerical pain level for mild pain. Further review of the orders for oxycodone failed to document numerical number or pain level parameters for administration.</p> <p>During an interview with the Nursing Home Administrator on July 15, 2024, at 3:15 PM, it was revealed that the orders for the acetaminophen and the oxycodone should've contained pain level parameters for administration. No further information was provided regarding the hospital recommendation for as needed Tramadol.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa Code 211.12(c)(d)(1)(5) Nursing Service</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46253</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for one of 31 residents reviewed (Resident 96).</p> <p>Findings include:</p> <p>Review of Resident 96's clinical record revealed diagnoses that included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and post-traumatic stress disorder (PTSD-a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event with triggers that can bring back memories of the trauma accompanied by intense emotional and physical reactions).</p> <p>Review of Resident 96's current physician orders revealed an order for depakote (divalproex sodium-a medication used for the treatment of bipolar disorder) 25 milligrams administer three tablets daily at bedtime, dated June 4, 2024.</p> <p>Review of Resident 96's psychiatry consult dated June 14, 2024, revealed a recommendation for a valproic acid level (a blood test used to determine safe dosing of depakote). Further, the review failed to reveal documentation that it had been reviewed by Resident 96's physician.</p> <p>Further review of Resident 96's physician orders failed to reveal an order for a valproic acid level.</p> <p>During an interview with the Nursing Home Administrator and Employee 8 Regional Director of Clinical Services (RDCS) on July 11, 2024, at 2:06 PM, Employee 8 RDCS indicated that they could not provide documentation that Resident 96's physician had reviewed the psychiatry consult report, which included the recommendation for the laboratory order and, therefore, no order had been obtained. She further indicated that Resident 96 had an order to obtain the lab in May 2024, but the Resident was in the hospital at the time. She also shared that the hospital records did not reveal the laboratory test had been obtained while hospitalized. Employee 8 RDCS indicated they would follow-up with Resident 96's physician regarding the psychiatry consult and recommendation.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services</p>		

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NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253</b></p> <p>Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, to promote healing of a pressure ulcer for two of three residents reviewed for pressure ulcers (Residents 1 and 135).</p> <p>Findings include:</p> <p>Review of facility policy, titled Dressings, Dry/Clean, with a last revised date of September 2013, revealed the following, in part: 6. Put on clean gloves. Loosen tape and remove soiled dressing; 7. Pull glove over dressing and discard into plastic or biohazard bag; 8. Wash and dry your hands thoroughly; 13. Put on clean gloves; 14. Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage; 15. Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward); 16. Use dry gauze to pat the wound dry; and 17. Apply the ordered dressing.</p> <p>Review of Resident 1's clinical record revealed diagnoses that included multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves which disrupts communication between the brain and the body) and quadriplegia (partial or complete paralysis of both arms and both legs).</p> <p>Further review of Resident 1's clinical record revealed that the Resident had a stage 3 pressure ulcer (a full-thickness tissue loss wound where the tissue just under the skin may be visible, but no bone, tendon, or muscle is exposed) that was originally identified on February 28, 2024.</p> <p>Review of Resident 1's current physician orders revealed an order to cleanse the sacral wound with wound cleanser, apply silver alginate to wound base, apply medical honey to maceration (the softening and breaking down of skin resulting from prolonged exposure to moisture), and cover with an ABD (absorbent dressing) twice a day and as need for soiling or dislodging, dated July 2, 2024.</p> <p>Observation of Resident 1's dressing change on July 11, 2024, at 9:47 AM, performed by Employee 5 revealed that Employee 5 removed Resident 1's old dressing, cleansed the wound, and then removed their gloves, washed their hands, applied new gloves, and applied the ordered treatment.</p> <p>During a follow-up interview with Employee 5 on July 11, 2024, at 10:32 AM, Employee 5 confirmed that they did not remove their gloves, wash their hands, and apply new gloves between removing Resident 1's old dressing and cleansing the wound.</p> <p>Review of Resident 1's progress notes revealed a dietary note dated March 28, 2024, at 10:02 AM, written by the dietician which indicated, in part, Stage 3 sacral wound and need for added protein. Daily protein needs increased 2 [secondary] to stage 3 wound and estimated at 80 grams per day, TF [tube feeding] providing ~[approximately] 70% of daily protein needs (57 grams per day). RECOMMENDATION: Obtain MD order for 30ml [milliliters] Pro-Stat (a protein supplement) Sugar Free (or house formulary equivalent) to provide [resident] with an added 17 g protein (TF + Pro-Stat= 74 grams per day).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident 1's current and historical physician orders failed to reveal an order for the protein supplement recommended by the dietician on March 28, 2024.</p> <p>During an interview with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Employee 8 (Regional Director of Clinical Services) on July 11, 2024, at 11:00 AM the NHA and DON confirmed that they would expect nurses to provide wound care according to facility policy. The NHA confirmed that the dietician's recommendation was not followed through with and that she would expect recommendations be addressed with a resident's physician for further orders. Employee 8 indicated that their current process was that the dietician would email nursing any recommendations for them to address with the resident's physician. She further revealed that they would be looking at the facility process.</p> <p>Review of Resident 135's clinical record revealed diagnoses that included severe protein-calorie malnutrition (malnutrition caused when not enough proteins and calories are consumed) and dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning).</p> <p>Further review of Resident 135's clinical record revealed that the Resident was admitted to the facility on [DATE], with a stage 2 pressure ulcer (a partial thickness tissue loss wound that does not go deeper than the dermis or middle layer of skin) and deep tissue injury (DTI - pressure-related injury to subcutaneous tissues under intact skin).</p> <p>Review of Resident 135's admission nutritional assessment dated [DATE], revealed a recommendation to obtain a physician's order for Vitamin C 500 milligrams, Zinc 220 milligrams, and a multi-vitamin for 14 days based on Resident 135's protein-calorie malnutrition, stage 2 pressure ulcer, DTI, and use of a diuretic.</p> <p>Review of Resident 135's progress note dated February 6, 2024, at 1:27 PM, by the dietician indicated that Resident 135 had experienced a significant weight loss over the past seven days, and again gave the recommendation to obtain a physician's order for vitamin C 500 milligrams, zinc 220 milligrams, and a multi-vitamin for 14 days.</p> <p>Review of Resident 1's historical physician orders failed to reveal an order for the Vitamin C, Zinc, or multivitamin recommended by the dietician on February 2, 2024, and February 6, 2024.</p> <p>During an interview with the NHA, DON, and Employee 8 on July 11, 2024, at 10:56 AM, Employee 8 indicated that they had no additional information to provide to show that the dietician's recommendations were reviewed with Resident 135's physician. The NHA confirmed that the dietician's recommendation was not followed through with and that she would expect recommendations to be addressed with a resident's physician for further orders. Employee 8 indicated that their current process was that the dietician would email nursing any recommendations for them to address with the resident's physician. She further revealed that they would be looking at the facility process.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident Care Policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing Services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>48484</p> <p>Based on clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to ensure residents with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for two of 10 residents reviewed for limited range of motion (Residents 10 and 84).</p> <p>Findings include:</p> <p>Review of Resident 10's clinical record revealed diagnoses that included left hand contracture (a permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult), chronic obstructive pulmonary disease (COPD - a group of lung disease that block airflow and make it difficult to breathe), and muscle weakness.</p> <p>Review of Resident 10's physician orders revealed an order for Left c grip hand splint. On with AM cares, off with PM cares, with a start date of January 25, 2024.</p> <p>Review of Resident 10's care plan revealed a focus area The resident has activities of daily living self-care performance deficits related to limited range of motion, last revised November 16, 2022, with an intervention for Left c grip hand splint. On with AM cares, off with PM cares, initiated on November 29, 2023.</p> <p>Observation of Resident 10 in her room on July 8, 2024, at 10:33 AM, 12:02 PM, and 1:39 PM, failed to reveal her wearing a c grip hand splint.</p> <p>Review of Resident 10's nurse aide documentation on July 8, 2024, at 11:20 AM, revealed Employee 9 (Nurse Aide) checked yes to indicate the hand splint was in place.</p> <p>Observation of Resident 10 in her room on July 9, 2024, at 9:22 AM, and 11:06 AM, failed to reveal her wearing a c grip hand splint.</p> <p>Review of Resident 10's nurse aide documentation on July 8, 2024, at 10:37 AM, revealed Employee 10 (Nurse Aide) checked yes to indicate the hand splint was in place.</p> <p>Observation of Resident 10 in her room on July 10, 2024, at 11:26 AM, failed to reveal her wearing a c grip hand splint.</p> <p>Interview with Resident 10 on July 10, 2024, at 11:27 AM, revealed she does not wear a hand splint.</p> <p>Interview with the Director of Nursing (DON) on July 11, 2024, at 1:31 PM, revealed she would expect physician orders to be followed and expect staff not to sign off the brace was in place when it was not applied.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 84's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), and muscle weakness.</p> <p>Review of Resident 84's physician orders revealed an order for Left resting hand splint on with AM cares, off with PM cares, with a start date of January 24, 2024.</p> <p>Further Review of Resident 84's physician orders revealed an order for Bilateral Geri sleeves- to be worn removed for cares as resident allows, with a start date of January 31, 2024.</p> <p>Observation of Resident 84 on July 8, 2024, at 10:36 AM, 12:00 PM, and 1:39 PM, failed to reveal her wearing a left resting hand splint or gerisleeves.</p> <p>Review of Resident 84's nurse aide documentation on July 8, 2024, at 11:27 AM, revealed Employee 9 checked yes to indicate the hand splint and gerisleeves were in place.</p> <p>Observation of Resident 84 on July 9, 2024, at 9:34 AM, 10:58 AM, failed to reveal her wearing a left resting hand splint or gerisleeves.</p> <p>Review of Resident 84's nurse aide documentation on July 9, 2024, at 10:42 AM, revealed Employee 10 checked yes to indicate the hand splint and gerisleeves were in place.</p> <p>Interview with the DON on July 10, 2024, at 1:33 PM, revealed she would expect physician orders to be followed and expect staff not to sign off they were in place if not applied.</p> <p>28 Pa. Code 211.12(d)(1)(3)(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>47966</p> <p>Based on review of clinical records and staff interviews, it was determined that the facility failed to provide interventions to prevent accidents for one out of six residents reviewed for accident hazards (Resident 48).</p> <p>Findings include:</p> <p>Review of Resident 48's clinical record revealed diagnoses that included hypertension (high blood pressure) and chronic respiratory failure (when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body).</p> <p>Review of Resident 48's clinical record revealed the Resident had a fall off their bed on March 13, 2024, while receiving bathing assistance in bed by one nurse aid.</p> <p>Review of Resident 48's clinical record revealed that, after the fall on March 13, 2024, their comprehensive person-centered care plan was updated on March 18, 2024, with an intervention for bed mobility to include the resident requires assist of two to reposition and turn in bed.</p> <p>Further review of Resident 48's clinical record revealed an Activities of Daily Living Bed Mobility task, which included the support that was provided relating to how the resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture. Review of the task revealed Resident 48 received bed mobility assistance with only one-person physical assist on the following days: June 11, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, and 29, 2024; and July 2, 3, 6, 7, 8, 9, 10, and 11, 2024.</p> <p>During an interview with the Nursing Home Administrator on July 11, 2024, at 1:32 PM, she revealed that she would have expected Resident 48's care plan to have been followed with receiving two staff assist when completing bed mobility.</p> <p>28 Pa. Code 201.18(b)(1)(2)Management</p> <p>28 Pa. Code 211.12(d)(3)(5)Nursing services</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>37013</p> <p>Based on facility policy review, clinical record review, and staff interviews, it was determined the facility failed to ensure proper monitoring to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, for one of seven residents reviewed (Resident 47), and failed to notify the physician of a significant weight loss for one of seven residents reviewed for nutritional status (Resident 81).</p> <p>Findings include:</p> <p>Review of facility policy, titled Weight Assessment and Intervention, dated March 2019, revealed The nursing staff will measure resident weight on admission, and then weekly for four weeks. If no weight concerns are noted at this point, weights will be measured monthly thereafter or as per Dietician or MD.</p> <p>Review of Resident 47's clinical record revealed diagnoses that included dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>Review of Resident 47's clinical record revealed a weight change progress note, dated April 24, 2024, that Resident 47 had a significant weight loss of 11.1% over the past 180 days.</p> <p>Further review of Resident 47's clinical record revealed a weight change progress note, dated May 14, 2024, stating that Resident 47 had a 13% weight loss over the past 180 days.</p> <p>Review of Resident 47's clinical record revealed an order, dated May 2, 2024, for monthly weights, every evening shift on the 2nd day.</p> <p>Review of Resident 47's clinical record revealed no documented weight for July 2024.</p> <p>Review of Resident 47's treatment administration record (TAR) dated July 2024, revealed that on July 2, 2024, Resident 47's monthly weight was signed off as 16, meaning hold/see nurse notes.</p> <p>Review of Resident 47's corresponding nurse's note revealed that the weight was not obtained.</p> <p>During an interview with the Nursing Home Administrator (NHA) on July 11, 2024, at 12:43 PM, she confirmed that Resident 47 was not weighed on July 2, 2024, per order and stated that she was being weighed now.</p> <p>Review of Resident 81's clinical record revealed diagnoses that included dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory and abstract thinking), dysphagia (difficulty swallowing), and feeding difficulties.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 81's weigh history documented: January 1, 2024, a weight of 108.5 pounds (lb- unit of measure); February 5, 2024, a weight of 100.8 lb (a 7.7 lb loss, 7% loss in one month); and July 1, 2024, a weight of 97.9 lb (10.6 lb loss, 10% loss in 6 months).</p> <p>Review of resident 81's Nutrition progress notes revealed a nutrition assessment was completed on January 18, 2024; documented weight was stable. The next nutrition note was dated April 18,2024, read, in part, 13% weight loss (14 lb) over the past 90 days. Resident ability to feed herself varied from independent to totally dependent. Nutrition interventions in place to prevent further weight loss; fortified food three times a day, milk, and juice three times a day and ice cream twice a day. Continue with current nutrition interventions. Recommend nursing to encourage beverages between meals and snack.</p> <p>Further review revealed the next nutrition note was dated July 9, 2024, read, in part, weight on July 1, 2024, was 97.9lb, a 10.1 % weight loss in 180 days. Nutrition interventions in place stabilizing weight over the past five months. Nutrition interventions in place include fortified foods three times a day milk and juice three times a day, and ice cream twice a day. Meal intake 25% to 100% over past 14 days. Continue current nutritional interventions. Recommend nursing to encourage beverages between meals and snack.</p> <p>Further clinical record review failed to document that the physician was notified or acknowledged Resident 81's significant weight loss.</p> <p>During an interview with Employee 8 (Regional Nurse Manager) and the Director Of Nursing on July 10, 2024, at 1:54 PM, it was revealed that they would expect nursing to notify the physician of the significant weight loss.</p> <p>During an interview with the Employee 8 on July 10, 2024, at 3:23 PM, it was revealed that she called the Registered Dietitian (RD) and Resident 81's weight warning note was inadvertently missed in February 2024. It was also revealed that the RD will document an initial weight warning note and quarterly charting; monthly nutrition risk charting isn't necessarily expected.</p> <p>28 Pa. Code 211.12(d)(1)(3)(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>47966</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observations, clinical record review, policy review, and resident and staff interviews, it was determined the facility failed to provide respiratory care consistent with professional standards of practice for two of four residents reviewed for respiratory care (Residents 57 and 397).</p> <p>Findings include:</p> <p>Review of facility policy, titled Oxygen Therapy, last reviewed April 2024, revealed that a physician must order the oxygen therapy.</p> <p>Review of Resident 57's clinical record revealed diagnoses that included peripheral vascular disease (a slow and progressive circulation disorder caused by narrowing, blockage, or spasms in a blood vessel) and hypertension (high blood pressure).</p> <p>During an observation of Resident 57 on July 8, 2024, at 11:13 AM, revealed Resident 57 was currently using oxygen. Further observation revealed the oxygen tubing was not dated.</p> <p>During an interview with Resident 57 on July 8, 2024, at 11:13 AM, revealed Resident 57 had been using oxygen for four days.</p> <p>Review of Resident 57's clinical record revealed a progress nursing note dated July 4, 2024, at 6:29 PM, with the following note text: Supplemental oxygen applied with positive effect.</p> <p>Review of Resident 57's clinical record on July 8, 2024, revealed there was no order for oxygen to be administered or an order to change the oxygen tubing.</p> <p>Review of Resident 57's clinical record on July 9, 2024, revealed an order for O2 at 2 liters per minute via nasal canal every shift for shortness of breath or to maintain oxygen saturation above or equal to 90%, with an active date of July 9, 2024.</p> <p>During an interview with the Director of Nursing (DON) on July 10, 2024, at 1:47 PM, revealed Resident 57 should have had an order for oxygen prior to July 9, 2024, should have an order to change the oxygen tubing weekly, and that she would expect the oxygen tubing to be dated.</p> <p>Review of Resident 397's clinical record revealed diagnoses that included hypertension (high blood pressure) and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities).</p> <p>Observation of Resident 397 on July 9, 2024, revealed the Resident was using oxygen, with no date on the oxygen tubing.</p> <p>Review of Resident 397's clinical record revealed a physician's order for O2 at 2 liters per minute via nasal canal, with an active date of June 28, 2024. Further review of Resident 397's physician's orders revealed no order for the oxygen tubing to be changed.</p> <p>(continued on next page)</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>Review of Resident 397's comprehensive person-centered care plan revealed an intervention to change and label oxygen tubing and clean concentrator filter weekly and as needed, with an initiation date of July 2, 2024.</p> <p>During an interview with the DON on July 10, 2024, at 1:47 PM, she revealed that Resident 397 should have an order for their oxygen tubing to be changed weekly, and that the tubing should be dated.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48484</b></p> <p>Based on facility policy reviews, observations, and staff interviews, it was determined that the facility failed to store food and utilize equipment in accordance with professional standards for food service safety in the main kitchen, two of two nourishment areas, and one of two medication storage areas.</p> <p>Findings include:</p> <p>Review of facility policy, titled General Food Preparation and Handling, last revised [DATE], read, in part, Food items will be prepared to consume maximum nutritive value, develop, and enhance flavor and free of injurious organisms and substances. The kitchen and equipment are clean. Foods are received, checked, and stored properly as soon as they are delivered. Leftovers must be dated, labeled, cooled, and stored.</p> <p>Review of facility policy, titled Food from Outside Sources, revised [DATE], read, in part, Visitor/family member will label food and beverages with the resident's name, room number and date. Perishable foods with a 'use by' date which is 3 days from the date that it was brought into the facility.</p> <p>Observation of the dry storage area in the main kitchen on [DATE], at 9:19 AM, revealed three bags of cut ziti not dated; four packs of hamburger buns not dated; four bags of sliced bread not dated; a bin of individually wrapped cookies not dated; four boxes of oatmeal cream pies not dated; a bag of instant vanilla pudding not dated; and two bags of fudge brownie mix not dated.</p> <p>Observation of reach-in refrigerator 1 on [DATE], at 9:29 AM, revealed the bottom of the refrigerator was heavily soiled and there was a dead housefly stuck in the soilage.</p> <p>Observation in the main kitchen on [DATE], at 9:33 AM, revealed three loaves of bread with one open, all not dated; one open container of peanut butter without an open date; one open container of instant mashed potatoes without an open date; a shelf of open spices containing lemon pepper, ginger, oregano, sage, basil, dill weed, chili powder, onion, paprika, and ground mustard all not dated with an open date; whole poppy seeds dated use by [DATE]; thyme labeled use by [DATE]; nutmeg labeled use by [DATE]; and five packages of stuffing seasoning mix not dated.</p> <p>During an observation of the three-compartment sink in the main kitchen on [DATE], at 9:36 AM, the surveyor requested Employee 1 (Dietary Aide) to test the concentration of the sanitizer water, Employee 1 tested the water with a test strip that did not change color.</p> <p>Surveyor review of the test strips used to test the water on [DATE], at 9:36 AM, revealed they were the incorrect test strips based on the sanitizer being used.</p> <p>Further observation of the three-compartment sink in the main kitchen on [DATE], at 9:39 AM, revealed a different set of strips were used to test the water, which were the correct strips, and revealed the appropriate concentration of the water. Surveyor observation of the correct test strips revealed an expiration date of [DATE].</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  990 Medical Road Millersburg, PA 17061	
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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>Observation of the ice machine in the main kitchen on [DATE], at 9:40 AM, revealed a fuzzy grey substance surrounding the vent of the machine.</p> <p>Further observation inside the ice machine in the main kitchen on [DATE], at 9:40 AM, revealed a black substance on the top and sides of the machine.</p> <p>Observation of walk-in freezer on [DATE], at 9:46 AM, revealed: one bag of chicken patties dated use by [DATE]; one bag of meat patties not dated; one bag of ground sausage not dated; and one bag of hot dogs not dated.</p> <p>Observation of the ice machine in the second Floor nourishment area on [DATE], at 9:51 AM, failed to reveal an air gap between the floor drain and the drain to the ice machine.</p> <p>Observation of the second Floor nourishment area refrigerator on [DATE], at 9:54 AM, revealed a container of thickened lemon water labeled best used by [DATE]; one container with a deli sandwich from an outside source dated [DATE]; and the following food items from outside sources not dated: one container of soup; one container with a deli sandwich; one bag of fruit; one container of fruit; one meat and cheese platter and one prepared meal.</p> <p>Observation of the first Floor nourishment area refrigerator on [DATE], at 10:01 AM, revealed a grocery bag full of individual cheese slices from an outside source not dated, and one container of thickened apple juice open without an open date.</p> <p>Interview with Employee 2 (Registered Nurse) on [DATE], at 10:03 AM, revealed juice containers should be labeled with an open date when opened.</p> <p>Follow-up observation inside the ice machine in the second Floor nourishment area on [DATE], at 10:27 AM, revealed a black substance on the top of the machine.</p> <p>During an interview with Employee 3 (Dietary Manager) on [DATE], at 11:25 AM, he revealed he has ordered new sanitizer strips for the three-compartment sink, he would expect stored food items to be labeled, dated, and discarded once expired, and facility equipment to be cleaned and utilized in accordance with professional standards.</p> <p>Observation in the second floor medication room nourishment refrigerator on [DATE], at 9:45 AM, revealed the following food items from outside sources without resident's names and not dated: one container of pasta salad, one container of soup, one Styrofoam bowl covered with aluminum foil, and one container of hot dogs.</p> <p>Interview with the Nursing Home Administrator on [DATE], at 1:28 PM, she confirmed the facility's expectation that food items and kitchen equipment should be stored, cleaned, and utilized in accordance with professional standards.</p> <p>28 Pa. Code 211.6(f) Dietary services</p> <p>28 Pa. Code 201.18(b)(3)(e)(2.1) Management</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>37013</p> <p>Based on a review of facility documents it was determined that the facility failed to ensure sufficient nursing staff to comply with state laws regarding mandated minimum staffing requirements.</p> <p>Findings include:</p> <p>Review of 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations, S211.12 Nursing Services, dated February 23, 2023; with an effective date of July 1, 2023, indicated the following subsections.</p> <p>(f.1) In addition to the director of nursing services, a facility shall provide all of the following:</p> <p>(2) Effective July 1, 2023, a minimum of 1 nurse aide (NA) per 12 residents during the day, 1 NA per 12 residents during the evening, and 1 NA per 20 residents overnight.</p> <p>(3) Effective July 1, 2024, a minimum of 1 NA per 10 residents during the day, 1 NA per 11 residents during the evening, and 1 NA per 15 residents overnight.</p> <p>(4) Effective July 1, 2023, a minimum of 1 LPN (licensed practical nurse) per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight.</p> <p>(i) A minimum number of general nursing care hours shall be provided for each 24-hour period as follows:</p> <p>(1) Effective July 1, 2023, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.87 hours of direct resident care for each resident.</p> <p>(2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.</p> <p>Review of surveys completed from July 7, 2023, to July 11, 2024, revealed the following:</p> <p>Survey of July 7, 2023:</p> <p>-Facility failed to ensure a minimum of one NA per 12 residents on day and evening shift and failed to ensure a minimum of one NA per 20 residents on the overnight shifts, for four of five days reviewed (July 1, 2, 3, and 6, 2023).</p> <p>(continued on next page)</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Facility failed to ensure a minimum of one LPN per 25 residents during the day and one LPN per 30 residents during the evening for two of five days reviewed (July 1 and 2, 2023).</p> <p>- Facility failed to provide the minimum hours of direct care for each resident on three of four days reviewed (July 1, 2 and 3, 2023).</p> <p>Survey of August 21, 2023:</p> <p>-Facility failed to ensure a required minimum of one NA per 12 residents on day shift on two days; failed to ensure a required minimum of one NA per 12 residents on evening shifts for five days; and failed to ensure one NA per 20 residents on night shift on two days out of seven days reviewed for staffing (August 11, 13, 14, 15, and 16, 2023).</p> <p>-Facility failed to ensure a minimum of one LPN per 40 residents on night shift for one of seven days reviewed for staffing (August 13, 2023).</p> <p>Survey of September 25, 2023:</p> <p>-Facility failed to ensure a required minimum of one NA per 12 residents on day shift on four days; failed to ensure a required minimum of one NA per 12 residents on evening shifts for six days; and failed to ensure one NA per 20 residents on night shift on three days out of eight days reviewed for staffing (September 14-21, 2023).</p> <p>Survey of November 2, 2023:</p> <p>-Facility failed to ensure a required minimum of one NA per 12 residents on day shift on two days; failed to ensure a required minimum of one NA per 12 residents on evening shifts for 12 days; and failed to ensure one NA per 20 residents on night shift for five days out of 14 days reviewed for staffing (October 19, 2023 through November 1, 2023).</p> <p>Survey of November 15, 2023:</p> <p>-Facility failed to ensure a required minimum of one NA per 12 residents on evening shifts for two days; and failed to ensure one NA per 20 residents on night shift for two days out of seven days reviewed for staffing (November 10 and 13, 2023).</p> <p>Survey of December 29, 2023:</p> <p>-Facility failed to ensure a required minimum of NA per 12 residents on day shift for twelve out of twenty-two days (December 9, 10, 11, 15, 17, 18, 20, 21, 22, 23, 24, and 25, 2023); one NA per 12 residents on evening shifts for eighteen days of twenty-two days (December 5, 6, 7, 8, 9, 11, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, and 26, 2023); and failed to ensure one NA per 20 residents on night shift for three days out of twenty-two days reviewed for staffing (December 11, 23, and 25, 2023).</p> <p>Survey of March 25, 2024:</p> <p>(continued on next page)</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Facility failed to ensure a required minimum of one LPN per 25 residents on day shift for one of seven days (March 10, 2024); one LPN per 30 residents during the evening shift for three of seven days (March 8, 9, and 10, 2024); and one LPN per 40 residents during the night shift for three of seven days reviewed (March 6, 7, and 9, 2024).</p> <p>-Facility failed to ensure the total number of nursing care hours provided in each 24-hour period be a minimum of 2.87 hours of direct care for each resident for two of seven days reviewed (March 8 and 10, 2024).</p> <p>Survey of March 26, 2024:</p> <p>-Facility failed to ensure a required minimum of one NA per 12 residents on day shift for two of seven days (March 8 and 10, 2024) and one NA per 12 residents on evening shift for four of seven days reviewed (March 5, 6, 7, and 8, 2024).</p> <p>Survey of May 2, 2024:</p> <p>-Facility failed to ensure a required minimum of one NA per 12 residents on day shift for one of seven days reviewed (April 28, 2024), one NA per 12 residents on evening shift for six of seven days reviewed (April 25-30, 2024), and one NA per 20 residents on the overnight shift for one of seven days reviewed (April 25, 2024).</p> <p>-Facility failed to ensure a required minimum of one LPN per 25 residents on day shift, one LPN per 30 residents on evening shift, and one LPN per 40 residents on night shift for one of seven days reviewed (April 28, 2024).</p> <p>-Facility failed to ensure the total number of nursing care hours provided in each 24-hour period be a required minimum of 2.87 hours of direct care for each resident for three of seven days reviewed (April 26, 28, and 29, 2024).</p> <p>Survey of June 13, 2024:</p> <p>-Facility failed to ensure a required minimum of one NA per 12 residents on day shift for one of seven days reviewed (June 8, 2024); one NA per 12 residents on evening shift for one of seven days reviewed (June 7, 2024); and one NA per 20 residents on the overnight shift for one of seven days reviewed (June 7, 2024).</p> <p>-Facility failed to ensure a required minimum of one LPN per 25 residents on day shift for one of seven days reviewed (June 9, 2024); one LPN per 30 residents on evening shift for two of seven days reviewed (June 7 and 9, 2024); and one LPN per 40 residents on night shift for five of seven days reviewed (June 4, 5, 7, 8, and 9, 2024).</p> <p>-Facility failed to ensure the total number of nursing care hours provided in each 24-hour period be a required minimum of 2.87 hours of direct care for each resident for two of seven days reviewed (June 7 and 8, 2024).</p> <p>Survey of July 11, 2024:</p> <p>(continued on next page)</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Facility failed to ensure a required minimum of one NA per ten residents on day shift for four of seven days reviewed (July 5-8, 2024); failed to ensure a required minimum of one NA per 11 residents on evening shift for three of seven days (July 5, 6 and 8, 2024); and failed to ensure a required minimum of one NA per 15 residents on night shift for four of seven days (July 4, 6, 7, 9, 2024).</p> <p>-Facility failed to ensure a required minimum of one LPN per 25 residents on day shift for four of seven days reviewed (July 5, 6, 7, 9, 2024); and failed to ensure a required minimum of one LPN per 40 residents on night shift for five of seven days reviewed (July 4, 5, 6, 8, 9, 2024).</p> <p>-Facility failed to ensure the total number of nursing care hours provided in each 24-hour period be a required minimum of 3.2 hours of direct care for each resident for six of seven days reviewed (July 4-9, 2024).</p> <p>28 Pa. Code 201.14(g) Responsibility of licensee</p> <p>28 Pa. Code 201.18(e)(1)(2) Management</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>47966</p> <p>Based on clinical record review, policy review, observations, and staff interview, it was determined that the facility failed to maintain infection control practices to prevent the spread of infection for one of nine residents reviewed for infection control (Resident 17).</p> <p>Findings include:</p> <p>Review of facility policy, titled Isolation - Multi Route Transmission-Based Precautions, last reviewed April 2024, revealed when a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and in front of the chart so that personnel and visitors are aware of the need for and type of precaution.</p> <p>Review of Resident 17's clinical record revealed diagnoses that included chronic atrial fibrillation (an irregular and often very rapid heart rhythm) and hypertension (high blood pressure).</p> <p>Further review of Resident 17's clinical record revealed a physician's order for contact precautions related to nasal MRSA (methicillin-resistance staphylococcus aureus), with an active date of May 24, 2024.</p> <p>Review of Resident 17's comprehensive person-centered care plan revealed an intervention for contact precautions related to nasal MRSA, with an initiation date of May 24, 2024.</p> <p>Observation of Resident 17's room on July 8, 9, 10, and 11, 2024, revealed no enhanced barrier precaution sign was posted on Resident 17's door.</p> <p>During a staff interview on July 10, 2024, at 1:43 PM, the Director of Nursing confirmed that Resident 17 is on transmission-based precautions, and would expect signage to be posted on their door indicating that Resident 17 is on transmission-based precautions.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>