

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Dubois Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 212 S. Eighth St. Dubois, PA 15801	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42079 Based on review of facility policy and clinical records, observations, and staff interviews, it was determined that the facility failed to enhance each resident's dignity by failing to provide clean durable medical equipment for one of 40 residents reviewed (Resident 105). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 105, dated May 23, 2024, revealed that the resident was somewhat understood and could somewhat understand others, and was dependent on staff for care care needs, including feeding assistance. A care plan for Resident 105 regarding an alteration in neurological status related to a cervical 4/cervical 5 surgical repair with discectomy (surgical removal of abnormal disc in the spine) indicated that the resident had a hard cervical collar (neck brace). Physician's orders for Resident 105, dated May 17, 2024, included an order for the resident to have a hard cervical collar in place at all time until further instructions were obtained from neurosurgery. Observations on June 24, 2024, at 12:17 p.m.; June 26, 2024, at 3:17 p.m.; and June 27, 2024, at 2:20 p.m. revealed that Resident 105's hard cervical collar had discoloration and a brown, red, removable substance on the padded areas around the chin, neck, and mouth areas. Interview with Nurse Aide 2 on June 27, 2024, at 2:20 p.m. confirmed that the neck brace was not clean. She explained that Resident 105 required feeding assistance following her surgery and that she tends to drool and food will fall out of her mouth. Interview with the Director of Nursing on June 27, 2024, at 2:57 p.m. confirmed that Resident 105's neck brace was soiled and not clean. 28 Pa. Code 201.29(j) Resident Rights.		

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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 31760 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to accommodate the residents' needs by failing to ensure the proper positioning needed for eating for one of 40 residents reviewed (Resident 10) who had nutritional and self-care concerns. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 10, dated June 7, 2024, revealed that the resident was usually understood, could usually understand others, had a diagnosis which included dementia, had a weight loss of 5 percent or more in the last month and/or a weight loss of 10 percent or more in last six months, was not on a prescribed weight-loss regimen, and received a therapeutic diet (e.g., low salt, diabetic, low cholesterol). A care plan for the resident, dated November 16, 2020, revealed that the resident had a potential for weight fluctuations related to variable PO (by mouth) intake. The resident was to be up in a Broda chair (an adaptive wheelchair) for breakfast then laid back down after lunch, then back up for supper. Physician's orders for Resident 10, dated February 27, 2024, included an order for the resident to be up in Broda chair for breakfast then laid back down after lunch then back up for supper, and the resident was to always have a Broda chair for mobility with leg rests. Observations in the third floor dining room during the lunch meals on June 24, 2024, at 12:12 p.m. and June 25, 2024, at 12:08 p.m. revealed that Resident 10 was sitting in a Broda chair at a table across from a male resident at the same table. The resident's Broda chair was in a slightly reclined position with the leg rests in place, which would not allow the resident's Broda chair to be placed close to the edge of the table. The table was raised to allow the resident's Broda chair and the male resident's specialized wheelchair to fit under the table. The resident had to fully extend her arm to obtain her food from the plate. The resident was observed placing her fork into the handle of a flow cup (a cup with a spouted lid that regulates the flow for controlled release of liquids) to pull the flow cup to the edge of the table, so she could grab the handle of the flow cup to take a drink. The resident also had small bowls of food beyond her plate that she was not able to reach. Interview with Licensed Practical Nurse 1 on June 25, 2024, at 12:41 p.m. confirmed that Resident 10's Broda chair would not sit up any straighter and that the table was raised in a higher position. Interview with the Dietitian on June 25, 2024, at 1:27 p.m. revealed that Resident 10's table needs to be in a higher position as to allow her Broda chair and the male resident's specialized wheelchair to be placed under the table. She indicated that they could have therapy re-evaluate the resident to see if there could be anything else done with her positioning during the meals. 28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31760 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to develop comprehensive care plans that included specific and individualized interventions to address the care needs for three of 40 residents reviewed (Residents 50, 62, 101). Findings include: The facility's policy for care planning, dated January 25, 2024, indicated that all residents will have an interim, comprehensive, and ongoing plan of care, which will be developed and reviewed by the interdisciplinary team and resident. The plan of care is a working tool and requires changes as needed to meet the residents needs. The resident is to be viewed as a whole to develop a blueprint for care. Unique characteristics and needs are to drive the process. It must be individualized, realistic, functional, and measurable at time frame for completion. All goals are to be related directly to the problem. It is to outline and provide directions to provide care for the resident to meet the goal. The facility's policy regarding Trauma Informed Care, dated January 25, 2024, revealed that the resident's input will be solicited, and the resident will be involved in the care planning process, if able. Trauma-specific interventions for a resident will be placed in their individualized, person-centered care plan upon admission and assessment. Care plans and interventions will be reviewed quarterly and more often, if necessary, based on any change in the resident's physical and psychosocial well-being. The facility's policy regarding Resident Smokeless Tobacco, dated January 25, 2024, revealed that the facility will provide a safe and healthy environment for residents, visitors, and employees, including safety as it is related to smokeless tobacco. Any resident who is deemed safe to utilize smokeless tobacco, with or without supervision, will be allowed to in accordance with his/her care plan. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 50, dated April 2, 2024, revealed that the resident was usually understood, could usually understand others, and had diagnoses that included dementia and PTSD. A care plan for the resident, dated January 19, 2024, revealed that the resident was a high risk for falls due Parkinson's disease, a history of falls, and cognitive status fluctuations, with a past occupation of being a Navy Seal who dismantled bombs during war time. Alarms (historically) discontinued due to resident constantly dismantling and causing him anxiety/triggers PTSD. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 50, dated March 3, 2024, revealed that after a quick nap, the resident had an episode of PTSD starting with aggressive/physical swinging of his fist. Staff tried to calmly redirect the resident, check, and change him, as well as offering him soda. The resident was not responding to staff and the PTSD was increasing. He was in the process of trying to self-transfer from bed to a standing position. Medication was applied and with a calm wait period the resident deescalated and became more at ease, and staff quickly finished dressing [NAME] and used a lift and sling to safely place him into his chair, and he was wheeled into the hall for staff to observe his actions. However, there was no documented evidence that Resident 50's care plan included specific and individualized interventions to address the care needs for his PTSD. Interview with the Nursing Home Administrator on June 26, 2024, at 12:40 p.m. confirmed that Resident 50's care plan did not include any specific and individualized interventions to address the care needs for his PTSD. A quarterly MDS assessment for Resident 62, dated April 1, 2024, revealed that the resident was clearly understood and could understand others, required assistance with care needs, received antipsychotic medication, and had diagnoses that included dementia. A care plan for Resident 62 regarding psychotropic medications, dated February 15, 2022, revealed that the resident had these medications related to depression, anxiety, and hallucinations with Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors). Physician's orders for Resident 62, dated October 17, 2023, included an order for resident to receive 5 milligrams (mg) of Abilify (antipsychotic medication) at bedtime for delusions and tearfulness. However, there was no documented evidence that Resident 62's care plan included specific and individualized interventions to address the care needs for her delusions and tearfulness and the use of antipsychotic medication with dementia. Interview with the Director of Nursing on June 27, 2024, at 2:57 p.m. confirmed that Resident 62's care plan did not include any specific and individualized interventions to address the care needs for her delusions and tearfulness and the use of antipsychotic medication with a dementia diagnosis. An admission MDS assessment for Resident 101, dated May 22, 2024, revealed that the resident was cognitively intact and required assistance with care needs, had diagnoses that included chronic kidney disease and heart failure, and received hospice services. Observations on June 24, 2024, at 2:51 p.m. revealed that Resident 101 had a container of smokeless tobacco (chewing tobacco) on his bed side table, and an interview with Resident 101 revealed that he has continued to use the smokeless tobacco since his admission to the facility. However, there was no documented evidence that Resident 101's care plan included specific and individualized interventions to address the use of smokeless tobacco. Interview with the Director of Nursing on June 26, 2024, at 1:24 p.m. confirmed that Resident 101's care plan did not include any specific and individualized interventions to address the use of smokeless tobacco. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31760 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to review and revise residents' care plans for five of 40 residents reviewed (Residents 2, 10, 22, 48, 105). Findings include: The facility's policy for care planning, dated January 25, 2024, indicated that the plan of care is a working tool and requires changes as needed to meet the residents' needs. The plan of care will also be reviewed and updated as needed during the change of status meeting. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated March 28, 2024, revealed that the resident was understood, able to understand others, required assistance with care needs, had two Stage 4 pressure ulcers (pressure wound with full thickness tissue loss with exposed bone, tendon or muscle), had complaints of pain rated a 5 of 10 on a pain scale of 0-10, and took routine and as-needed pain medication. A care plan for Resident 2, dated July 1, 2020, revealed that the resident had pain related to skin impairments. Physician's orders for Resident 2, dated March 3, 2024, included an order for the resident to receive a heat pack to his right hip as needed for right hip pain for 20 minutes on, then off at least 20 minutes with a washcloth placed between the heat pack and his skin. There was no documented evidence that Resident 2's care plan was revised to include the intervention for the heat pack to the right hip. Interview with the Nursing Home Administrator on June 27, 2024, at 10:56 a.m. confirmed that Resident 2's care plan was not revised to include the intervention for the heat pack to the right hip and it should have been. A quarterly MDS assessment for Resident 10, dated June 7, 2024, revealed that the resident was usually understood, could usually understand others, and had a diagnosis which included dementia. A care plan for the resident, dated November 16, 2020, revealed that the resident had a potential for weight fluctuations related to variable PO intake (by mouth). The resident was to have flow cups (a cup with a spouted lid that regulates the flow for controlled release of liquids), scoop plate (a non-skid rubber padded bottom designed to help users scoop food onto an eating utensil) and built-up fork and spoon at meals. Physician's orders for Resident 10, dated February 27, 2024, included an order for the resident to receive a consistent carbohydrate, regular texture, regular consistency, no salt packets, and flow cups for all beverages at meals. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations during the lunch meals on June 24, 2024, at 12:12 p.m. and June 25, 2024, 12:08 p.m. revealed that Resident 10 was sitting in a Broda chair (an adaptive wheelchair) at a table in the 3rd floor dining room. The resident had two flow cups; however, the resident did not have a scoop plate or a built-up fork and spoon. Interview with Licensed Practical Nurse 3 on June 25, 2024, at 12:45 p.m. confirmed that Resident 10 did not have a scoop plate or a built-up fork and spoon. However, there was no documented evidence that Resident 10's care plan was updated/revised to include that the resident does not use a scoop plate or a built-up fork and spoon. Interview with the Dietitian on June 25, 2024, at 1:27 p.m. confirmed that Resident 10's care plan was not updated/revised to include that the resident does not use a scoop plate or a built-up fork and spoon. A quarterly MDS assessment for Resident 22, dated May 17, 2024, revealed that the resident was sometimes understood, was able to sometimes understand others, required assistance with care needs, and had a history of falls. A care plan for Resident 22, dated November 30, 2018, indicated that the resident was at risk for abnormal bleeding related to taking an anticoagulant (medication that prevents or reduces risks of blood clots). However, there was no documented evidence that the resident was ordered an anticoagulant. Physician's orders for Resident 22, dated May 30, 2024, revealed that the resident was ordered transmission-based precautions for COVID infection through June 7, 2024. A care plan for Resident 22, dated September 8, 2020, indicated that the resident was on transmission-based precautions (precautions used to help prevent the spread of infections) related to COVID-19 infection. There was no documented evidence that Resident 22's care plan was revised to reflect that the resident was no longer on transmission-based precautions and that the resident no longer had COVID infection. Interview with the Director of Nursing on June 27, 2024, at 2:59 p.m. confirmed that Resident 22's care plan was not revised to reflect that she was not ordered an anticoagulant and confirmed that the resident was no longer on transmission-based precautions and no longer had COVID infection. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS assessment for Resident 48, dated May 24, 2024, revealed that the resident was cognitively intact, was understood and understands others, required assistance for care needs, had a surgical wound, and was receiving an antibiotic. A care plan for Resident 48, dated September 6, 2023, indicated that the resident had a Methicillin-resistant Staphylococcus aureus (MRSA) (type of staph bacteria resistant to many antibiotics making treatment difficult) infection to right bunion area and was on contact precautions (precautions used to prevent the spread of infection through direct or indirect contact). A care plan for Resident 48, dated May 1, 2024, indicated that the resident was on enhanced barrier precautions (an infection control intervention to reduce multidrug resistant organism (MDRO) transmission in nursing homes) related to surgical wound/amputation of right great toe and a history of MDRO (a germ that is resistant to many antibiotics making treatment difficult). A care plan for Resident 48, dated August 11, 2021, indicated that the resident was receiving an antibiotic for an infection to his right bunion wound and osteomyelitis (infection of the bone) of right foot. Physician's orders for Resident 48, dated May 1, 2024, indicated that the resident was on enhanced barrier precautions due to surgical wound/amputation of great right toe and a history of a MDRO. Physician's orders for Resident 48, dated June 18, 2024, indicated that the resident was ordered 800-160 milligrams of Bactrim DS (an antibiotic) twice daily for a wound infection for 14 days. A skin and wound note for Resident 48, dated June 18, 2024, at 3:41 p.m. revealed that the wound Certified Registered Nurse Practitioner (CRNP) saw the resident related to his right great toe amputation and ordered the Bactrim for infection prevention indicating that the bone culture done by [NAME] Care at the office visit the week prior showed no growth of any infection. There was no documented evidence that Resident 48's care plan was revised to reflect that the MRSA infection to right bunion area was resolved and he was no longer on contact precautions. There was no documented evidence that Resident 48's care plan was revised to reflect that the infection to his right bunion area and osteomyelitis of the right foot were resolved, and that the antibiotic was ordered for infection prevention related to his right great toe amputation. Interview with the Nursing Home Administrator on June 26, 2024, 2:00 p.m. confirmed that Resident 48's care plans were not revised to reflect that the MRSA infection to right bunion area and contact precautions were resolved and confirmed that the care plan for the antibiotic was not revised to reflect the resident's need for the antibiotic related to infection prevention to his right great toe amputation. An admission MDS assessment for Resident 105, dated May 23, 2024, revealed that the resident was somewhat understood and could somewhat understand others, was dependent on staff for care care needs, was at risk for pressure ulcers (wounds caused by pressure), and had a deep tissue injury (DTI) not present on admission. A care plan for Resident 105, regarding impaired skin integrity, dated May 17, 2024, revealed that the resident should not have complications related to the DTI to the right buttocks. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for Resident 105, dated June 7, 2024, included an order for wound care to the coccyx/buttock area for a Stage II pressure ulcer (partial thickness loss of skin as a shallow open ulcer). The area was to be cleansed with wound cleanser, pat dry, apply Xeroform (occlusive dressing), and cover with large foam dressing daily and as needed. A skin wound note for Resident 105, dated June 7, 2024, revealed that the pressure area to the right buttock was acquired in-house, and that the DTI was healed, but the resident had a cluster of new open areas to the coccyx and buttocks. Interview with the Director of Nursing on June 27, 2024, at 2:57 p.m. confirmed that Resident 105's care plan was not updated to reflect the care and treatment of the in-house acquired pressure areas and should have been. 28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48941 Based on review of clinical record reviews, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders for a maintenance nursing program were followed for one of 40 residents reviewed (Resident 22) and failed to complete wound treatments as ordered for one of 40 residents reviewed (Resident 48). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 22, dated May 17, 2024, revealed that the resident was sometimes understood and sometimes able to understand others and required assistance with care needs. A care plan for Resident 22, dated April 19, 2011, indicated that the resident was to receive a maintenance nursing program consisting of active range of motion (person can actively range a part of the body) to her right lower extremity and passive range of motion (person needs assistance from someone else to range a part of the body) to her left lower extremity twice daily with a.m. and p.m. care. Physician's orders for Resident 22, dated September 16, 2021, included an order for the resident to receive a maintenance nursing program consisting of active range of motion to her right lower extremity and passive range of motion to her left lower extremity twice daily with a.m. and p.m. care. Documentation in Resident 22's clinical record for May 2024 revealed that the maintenance nursing program consisting of active range of motion to her right lower extremity and passive range of motion to her left lower extremity was not documented as completed on the evening shift for April 3 and April 5, 2024, and documented as not applicable (NA) on the evening shift for May 4, 14, 20, 24, 28, 29 and 30. Documentation in Resident 22's clinical record for June 2024 revealed that the maintenance nursing program consisting of active range of motion to her right lower extremity and passive range of motion to her left lower extremity was not documented as completed on the day shift for June 3 and was documented as not applicable (NA) on the evening shifts for June 1, 2, 5, 6, 8, 10, 11, 12, 13, 15, 23, 24, 25 and 26. There was no documented evidence that the maintenance nursing program consisting of active range of motion to her right lower extremity and passive range of motion to her left lower extremity was completed as ordered on the above mentioned dates and shifts. Interview with the Director of Nursing on June 27, 2024, at 2:59 p.m. confirmed that the nursing maintenance program for Resident 22 was not completed as ordered and it should have been. She indicated she was not sure why the staff would be charting not applicable (NA) as they have been educated on this. The facility's policy for on Medication Administration Documentation, dated January 25, 2024, indicated that topical medications used in treatments are listed on the Electronic Treatment Administration Record (ETAR) and the licensed nurse will record the treatment was administered per the physician's order on the ETAR directly after the treatment has been completed. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48941 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that treatments for pressure ulcers were provided as ordered by the physician for one of 40 residents reviewed (Resident 2). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated March 28, 2024, revealed that the resident was understood, able to understand others, required assistance with care needs, and had two Stage 4 pressure ulcers (pressure wound with full thickness tissue loss with exposed bone, tendon or muscle). Physician's orders for Resident 2, dated January 25, 2024, included an order for the staff to clean the wound to the left ischium with Vashe wound cleanser (used to cleanse and debride wounds) and pat dry, pack wound with a piece of silver calcium alginate (dressing used to aid in wound healing), and cover with a foam dressing daily every day shift. A review of the resident's Treatment Administration Record (TAR) for April 2024 revealed that the resident did not receive the treatment on April 18, 2024, as ordered. Physician's orders for Resident 2, dated March 7, 2024, included an order for the staff to apply no-sting barrier film (used to protect broken or intact skin from irritation) to scar to left posterior thigh and cover with a foam dressing every other day on day shift and as needed for dislodgement. A review of the resident's TAR for April 2024 revealed that the resident did not receive the treatment on April 18, 2024, as ordered. Physician's orders for Resident 2, dated April 11, 2024, included an order for the staff to apply no-sting barrier film to a healed scar to left gluteal, allow to dry, and cover with a foam dressing daily every day shift to prevent the wound from reopening. A review of the resident's TAR for April 2024 revealed that the resident did not receive the treatment on April 18, 2024, as ordered. Physician's orders for Resident 2, dated May 16, 2024, included an order for the staff to clean the wound to the left ischium with Vashe wound cleanser, pat dry, apply skin prep (forms a barrier between skin and adhesives) to peri wound redness, pack with a piece of silver calcium alginate, cover with a Zetuvit foam dressing (absorbent dressing for wounds with drainage) daily every day shift, and peel back the foam to left posterior thigh to make sure wound remained healed daily. A review of the resident's TAR for May 2024 revealed that the resident did not receive the treatment on May 24, 2024, as ordered. Physician's orders for Resident 2, dated May 18, 2024, included an order for the staff to apply no-sting barrier film to the wound and peri area to left posterior thigh and cover with a foam dressing every three days on day shift and as needed for dislodgement. A review of the resident's TAR for May 2024 revealed that the resident did not receive the treatment on May 24, 2024, as ordered. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician's orders for Resident 2, dated May 23, 2024, included an order for the staff to clean the left gluteal with Vashe and gauze, pat dry, apply skin prep to the wound and peri-wound, apply Xeroform (non-adherent gauze dressing that prevents air and moisture loss to promote wound healing) with collagen powder (stimulates wound healing) to the wound bed, and cover with a foam dressing daily every day shift to prevent that wound from reopening. A review of the resident's TAR for May 2024 revealed that the resident did not receive the treatment on May 24, 2024, as ordered. Physician's orders for Resident 2, dated May 30, 2024, included an order for the staff to clean the wound to the left ischium with Vashe wound cleanser, apply skin prep to peri wound, pack wound with a piece of silver calcium alginate, and cover with a Zetuvit foam dressing daily every day shift. A review of the resident's TAR for June 2024 revealed that the resident did not receive the treatment on June 16, 2024 as ordered. Physician's orders for Resident 2, dated June 1, 2024, included an order for the staff to apply skin prep to left posterior thigh and cover with a foam dressing every three days on day shift for preventative care. A review of the resident's TAR for June 2024 revealed that the resident did not receive the treatment on June 16, 2024, as ordered. Physician's orders for Resident 2, dated June 1, 2024, included an order for the staff to clean left gluteal with Vashe and gauze, pat dry, apply skin prep to wound and peri-wound, apply foam dressing over the scar, and change every three days on day shift and as needed for dislodgement/soilage. A review of the resident's TAR for June 2024 revealed that the resident did not receive the treatment on June 16, 2024, as ordered. Interview with the Director of Nursing on June 27, 2024, at 2:23 p.m. confirmed there was no documented evidence that Resident 2 received wound treatments as ordered to the areas listed above on dates listed above. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31760 Based on review of facility policies, clinical records, and facility investigation reports, as well as observations and staff interviews, it was determined that the facility failed to provide an environment that was free of accident hazards for residents who were at risk for falls, by failing to follow physician-ordered and care-planned interventions for one of 40 residents reviewed (Resident 50), resulting in a fall; failed to ensure resident safety during transportation in a wheelchair for two of 40 residents reviewed (Residents 60, 80); and failed to ensure that air mattresses were assessed for potential safety hazards for one of 40 residents reviewed (Resident 61). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 50, dated April 2, 2024, revealed that the resident was usually understood, could usually understand others, and had diagnoses that included dementia and Parkinson's disease. A care plan for the resident, dated April 2, 2024, revealed that the resident was a high risk for falls due to Parkinson's disease, a history of falls, and cognitive status fluctuations. The resident was to have a large change in position alerting device to his side mattress when in bed to alert staff if he rolls onto the side of the mattress. Physician's orders for Resident 50, dated March 19, 2024, included an order for the resident to have an alarming fall matt to be placed on top of the floor mattress when in bed. A nursing note for Resident 50, dated April 8, 2024, revealed that the writer was called to the resident's room by the nurse aide. The resident was currently kneeling on the floor in front of his bathroom. He has been incontinent of a large amount of stool. Upon assessment the resident was found to have abrasions (an injury where your skin rubs off) to both of his knees and to the top of both of his feet. The resident also had bruising to both of his knees. No other injuries were noted. It was reported that the resident was having an electrocardiogram (EKG - a test to record the electrical signals in the heart), and at the time of the EKG the technician disabled the alarms to do the testing. No alarms were on at the time of fall. An investigation report for Resident 50, dated April 8, 2024, revealed that the technician had just done an EKG on the resident and commented about his alarms. The technician did not inform them that she had shut them off. A witness statement completed by Nurse Aide 4, dated April 8, 2024, revealed that no alarms were sounding because after the technician was done with the EKG the technician left without telling them or turning the alarms back on. An interdisciplinary note for Resident 50, dated April 9, 2024, revealed that the resident got up unassisted, likely due to bathroom needs as he had an incontinent episode of bowel at the time of the fall. The alarm did not sound as the EKG technician who was in to perform the EKG shut the alarm off while in there and forgot to turn them back on. The EKG technician was educated. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing on June 27, 2024, at 11:21 a.m. confirmed that Resident 50's alarms were not turned on prior to the fall on April 8, 2024, as ordered by the physician and as care planned. She indicated that the EKG technician should have turned the alarms back on or have told staff that the alarms were off, so that they could turn them back on. An admission MDS assessment for Resident 60, dated March 22, 2024, and April 10, 2024, indicated that the resident was cognitively impaired and required assistance from staff with her daily care needs. Observations on June 25, 2024, at 12:08 p.m. revealed that Nurse Aide 5 was transporting Resident 60 to the dining room in a wheelchair without leg rests. Interview with Nurse Aide 5 on June 25, 2024, at 12:14 p.m. revealed that he was aware that leg rests were to be used when transporting Resident 60 in her wheelchair. Interview with Nursing Home Administrator on June 25, 2024, at 12:44 p.m. confirmed that staff should be using leg/footrests on wheelchairs when residents are being transported in their wheelchairs. A significant change MDS assessment for Resident 61, dated April 10, 2024, indicated that the resident was cognitively intact, required assistance from staff with her daily care needs, and was on hospice. Physician's orders, dated May 6, 2024, included an order to check the function of the low air loss mattress. A skin wound note for Resident 61, dated May 7, 2024, revealed that she had a new in-house acquired Stage II pressure ulcer (a shallow open wound) and that hospice provided the resident with an air mattress yesterday due to complaints of soreness on her buttock and coccyx area. Observations on June 24, 2024, at 11:45 a.m. and June 26, 2024, at 3:19 p.m. revealed that Resident 61 was lying in bed and the bed was equipped with an air mattress; however, there was no documented evidence that the use of an air mattress was assessed for potential safety hazards prior to being placed on the resident's bed. Interview with the Director of Nursing on June 27, 2024, at 2:57 p.m. confirmed that there was no assessment for potential safety hazards prior to the air mattress being placed on the Resident 61's bed and there should have been. An annual MDS assessment for Resident 80, dated March 14, 2024, revealed that the resident was cognitively impaired and required extensive assistance for her daily care needs. Observations on June 25, 2024, at 12:25 p.m. revealed that Registered Nurse 6 transported Resident 80 in the hall way in a wheelchair without leg rests. Interview with Registered Nurse 6 on June 25, 2024, at 12:30 p.m. confirmed that she was aware that leg rests were to be used when transporting Resident 80 in her wheelchair. Interview with Nursing Home Administrator on June 25, 2024, at 12:44 p.m. confirmed that staff should be using leg/footrests on wheelchairs when residents are being transported in their wheelchairs. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 31760 Based on review of facility policies and clinical records, as well as staff interview, it was determined that the facility failed to ensure that residents were assessed and received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event) for one of 40 residents reviewed (Resident 50). Findings include: The facility's policy regarding Trauma Informed Care, dated January 25, 2024, revealed that upon admission the facility will assess each resident to ensure they receive appropriate treatment and services. A questionnaire will be utilized for each resident by the social services department to identify any trauma and/or post-traumatic stress disorder and to gather trigger information, so that our understanding of their traumatic events can be detailed and specific. Additional information may be obtained from the medical record, physical and emotional assessments, from the resident, from family members who have shared this information. Resident input will be solicited, and the resident will be involved in the care planning process, if able. An evaluation of the information received will be done to identify those risk factors/areas that we would want to include in our approaches with the resident. Social services personnel, in coordination with our interdisciplinary care team, will review the information given and work to develop methodologies and approaches to mitigate/eliminate those triggers. However, the facility's policy did not address current residents that had a diagnosis of PTSD. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 50, dated April 2, 2024, revealed that the resident was usually understood, could usually understand others, and had diagnoses that included dementia, and PTSD. A care plan for the resident, dated January 19, 2024, revealed that the resident was a high risk for falls due Parkinson's disease, a history of falls, and cognitive status fluctuations, with a past occupation of being a Navy Seal who dismantled bombs during war time. Alarms (historically) discontinued due to the resident constantly dismantling and causing him anxiety/triggers PTSD. A nursing note for Resident 50, dated March 3, 2024, revealed that after a quick nap, the resident had an episode of PTSD starting with aggressive/physical swinging of his fist. Staff tried to calmly redirect the resident, check and change him, as well as offering him soda. The resident was not responding to staff and the PTSD was increasing. He was in the process of trying to self-transfer from bed to a standing position. Medication was applied and with a calm wait period the resident deescalated, became more at ease, and staff quickly finished dressing and use a lift and sling to safely place resident into his chair, and he was wheeled into the hall for staff to observe his actions. However, there was no documented evidence that the facility completed a questionnaire for a history of trauma for Resident 50 to identify specific triggers that could re-traumatize the resident. (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Home Administrator on June 26, 2024, at 12:40 p.m. confirmed that there was no documented evidence of the questionnaire for a history of trauma being completed for Resident 50. He indicated that they only do the questionnaire for a history of trauma when a resident is a new admission to the facility. He indicated that they have not performed the questionnaire for a history of trauma on current residents. 28 Pa. Code 211.12(a)(d)(3)(5) Nursing Services.		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31760 Based on clinical record reviews, and staff interviews, it was determined that the facility failed to provide appropriate treatment and services for one of 40 residents reviewed (Resident 30) who had dementia. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 30, dated [DATE], revealed that the resident was sometimes understood, could sometimes understand others, and had diagnosis that included dementia and Parkinson's disease. A care plan for the resident, dated [DATE], revealed that the resident has an impaired cognitive function or impaired thought processes related to Parkinson's disease. Staff were to provide the resident with a homelike environment: visible clocks, a calendar, low-glare light, consistent care routines, familiar objects, and reduced sensory noise. Physician's orders for Resident 30, dated [DATE], and discontinued on [DATE], included an order for the resident to receive one 25 milligram (mg) tablet of Sertraline (a medication used for depression, panic disorders, obsessive-compulsive disorder, and social anxiety disorder) one time a day for depression. Physician's orders for Resident 30, dated [DATE], included an order for the resident to receive one 50 mg tablet of Trazodone (used to treat depression) at bedtime for restlessness. Physician's orders for Resident 30, dated [DATE], included an order for the resident to receive one 25 mg tablet of Trazodone three times a day as needed for restlessness. Physician's orders for Resident 30, dated [DATE], included an order for the resident to receive one 50 mg tablet of Sertraline one time a day for major depressive disorder (a mood disorder that interferes with daily life). A nursing note for Resident 30, dated [DATE], revealed that the writer received a call from the resident's niece. She stated that the resident calls her every morning at 5:30 a.m. and asks her to call the police as there are things going on here. He has told her that staff put people in the basement with a homelike environment: visible clocks, a calendar, low-glare light, consistent care routines, familiar objects, and reduced sensory noise. The man across the hall wants to beat him up. The resident's urine was recently tested and was negative. She feels that his dementia has progressed. The writer advised her that they would reach out to the physician. A nursing note for Resident 30, dated [DATE], revealed that his as-needed Trazodone was given. The resident voiced that the resident across the hall was screaming all day and into the night, and that it reminds him of his dead daughter. The resident said that his daughter is across the hall screaming for help and that she took too much dope. The resident said he is getting out of bed to go across the hall to let his daughter sleep in his bed tonight. (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note for Resident 30, dated [DATE], revealed that the resident's niece phoned in regard to the resident's paranoid behaviors. It was explained to her that the resident was ordered Trazadone 50 mg three times per day, and she stated that this medication was for sleep. She also wanted him moved to a different unit. Advised her that she would have to speak with social services regarding any room changes. A nursing note for Resident 30, dated [DATE], at 10:30 a.m. revealed that the writer instructed the resident to continue to self-propel down the hallway, as he is sitting outside of Resident 18's room, staring at her. I do believe that this is upsetting to Resident 18. A nursing note at 11:44 a.m. revealed that the resident thinks his deceased daughter is in the room across the hall from him and he yells across the hall for most of shift. Medication for given for restlessness/behaviors was not effective. The resident was yelling to get his lawyer because he is not permitted to see his daughter and she needs attention. When Resident 18 yells out or turns up her television, the resident becomes confused and agitated. A nursing note for Resident 30, dated [DATE], revealed that the resident began yelling at 5:20 a.m. that morning. The resident was yelling toward the hallway stating, Come in here and I'll tell you everything I know, multiple times. The resident was unable to be redirected at this time. The resident appeared to be confused at that time. A social service note for Resident 30, dated [DATE], at 3:43 p.m. revealed that they spoke with the resident about moving rooms, due to his niece's request, who is also his power of attorney. The resident stated that he does not really want to move, but that he would think about it. He states that if it's quieter up there maybe I'll go. He informed the writer that he cannot sleep with a bunch of noise. The writer advised him that they understand and that they would let the staff up there know. The writer also advised him that it may be better up there for him due to the resident across the hall yelling and getting the resident all worked up. The resident said, Yeah, they are always fighting over there. Currently the resident across the hall's television is up too loud, and the resident voiced, See, don't you hear them yelling over there and fighting. The writer attempted to redirect the resident and let him know it was the television, but he did not think it was and insisted he hears them yelling. The writer advised the resident that they could move his rooms tonight if he is willing, and he stated that he would think about it. The writer informed the nurse aides of this. A social service note at 6:32 p.m. revealed that the writer called and updated the resident's niece with the status of the room change, as she requested a room change for the resident. The writer advised her that he was prompted about a room change, in which he stated that he is not sure he wants to do. He informed the writer that he would think about it and decide. He stated that if it is quiet up there, he would go up there, but he was not sure yet. The writer advised him to think about it and encouraged him to try it out, and if he truly did not like it, they could look at an alternative room placement. The resident's niece stated that she was not happy with that, that the resident is stating that he does not want to move because he calls her daily at 6:00 a.m. telling her he wants out of here because the television is too loud and the lady across the hallway is yelling and fighting. She stated that she wants him moved and she would like to speak with him if he does not move. She also asked what could be done if he does not want to move, and the writer advised the resident's niece that they were not sure that they could physically make him move if he does not want to, but that the writer would have to speak with administration and let her know. (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note for Resident 30, dated [DATE], revealed that the writer spoke with the resident, who was resting in bed. The writer asked him if he was ready to move upstairs today. He replied, No, I'm not going. Every time I have to pee, I have to S-H-I-T (spelling out the word) and I don't know how things will work up there. The writer assured him that upstairs is run the same, he would ring his bell for assistance from the staff. Again, he said No, maybe another day. A message was left with social services. A nursing note for Resident 30, dated [DATE], revealed that the resident was yelling out about his father being across the hall with his daughter (who is deceased) saying tuck, which is an old slogan/joke he used to say to her when she would stay over at her grandfather's house. The writer noted that his roommate's television was on, and the volume was turned up fairly loud, as well as the television across the hall. The resident was provided with support by the writer and social services. The writer advised the resident that his daughter or father were not across the hall. The resident was shown that there was no one in the room across the hall aside from another resident. The writer spoke with the resident about his family and let the resident reminisce about his family who have passed away. The resident was offered a drink/snack, which was declined. The writer advised the resident to come out into the hallway and look out the window, as he enjoys looking outside. A nursing note for Resident 30, dated [DATE], revealed that the resident was seen by the Certified Registered Nurse Practitioner (CRNP - a registered nurse (RN) who has advanced education and clinical training in a health care specialty area) from Med Management today and orders were received to increase the resident's Sertraline to 50 mg daily and to administer Trazadone 25 mg three times a day as needed for restlessness for 30 days. A nursing note for Resident 30, dated [DATE], revealed that the resident was having increased confusion that shift. The resident cannot sleep due to another resident across the hall from his bedroom yelling repeatedly, whom he believed is his deceased daughter. The resident was unable to be reoriented or redirected via any attempted interventions. A nursing note for Resident 30, dated [DATE], revealed that the resident was yelling into room [ROOM NUMBER] looking to fight his son-in-law. He thinks that he is in the room. Tried to redirect; however, was not successful. A nursing note for Resident 30, dated [DATE], revealed that the resident's niece called today. She was concerned that the resident's dementia is getting worse and that the issue with the resident across the hall is getting worse. She was going to try to come up in a month or so to visit and maybe talk to her uncle and someone about him moving. He called her and was telling her about it. He believes at times the other resident is his daughter and has some confusion about it. A nursing note for Resident 30, dated [DATE], revealed that the resident was in his wheelchair sitting in front of Resident 18's room yelling in to stop talking about him. The resident yelled in and called Resident 18 a cocksucker. Resident 18 is sleeping, her television is on, and the volume is at an acceptable level. When attempting to redirect the resident he becomes aggressive and agitated, stating not to move him away from the room. He states that his niece pays for him to be there, and he can do what he wants to do. (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note for Resident 30, dated [DATE], revealed that the resident was having increased anxiety and anxiousness. The resident stated that someone in room [ROOM NUMBER] kept calling him a cocksucker all night long and he wants to confront the person. The behaviors from room [ROOM NUMBER] have caused a ripple effect with the resident. He was observed emotionally upset and agitated upon awakening this morning. Staff tried to redirect him, without any positive results, and the resident was verbally abusive and uncooperative with his care. A nursing note for Resident 30, dated [DATE], revealed that the resident's niece called to say she was on the phone with the resident for an hour. She was concerned about the bizarre conversation she had with him. He spoke a lot about his dead daughter, who he says was yelling in the bed across from his room. He also spoke of staff trying to take him out in a car with the motive to kill him. The resident's niece was assured that the resident sometimes does talk this way and is safe there. There was no documented evidence that any new interventions were attempted to address Resident 30's increased anxiety, anxiousness, and confusion toward Resident 18 when he refused to be moved to a different room except to have his Sertraline dose increased and added Trazodone three times a day as needed. Interview with the Director of Nursing on [DATE], at 11:33 a.m. confirmed that Resident 30 has had an increase in his behaviors due to Resident 18, that the resident had to have an increase in his Sertraline dose, as well as add Trazodone three times a day as needed, and that there were no other new interventions attempted to address the resident's increased anxiety, anxiousness, and confusion toward Resident 18 when he refused to be moved to a different room. She indicated that Resident 18 knows that the resident thinks she is his deceased daughter and will call out daddy. 28 Pa. Code 211.12(d)(5) Nursing Services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Dubois Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 212 S. Eighth St. Dubois, PA 15801	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 31760 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to maintain compliance with nursing home regulations and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of correction for the State Survey and Certification (Department of Health) surveys ending July 27, 2023, and April 10, 2024, revealed that the facility developed plans of corrections that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending June 27, 2024, identified repeated deficiencies related to a failure to accommodate a resident's needs, to develop comprehensive care plans, to update residents' care plans, and to ensure that the residents' environment remained free from accident hazards. The facility's plan of correction for a deficiency regarding a failure to accommodate a resident's needs, cited during the survey ending July 27, 2023, revealed that audits would be conducted, and the results of the audits would be brought before the QAPI committee for further monitoring. The results of the current survey, cited under F558, revealed that the QAPI committee was ineffective in correcting deficient practices related to accommodating a resident's needs. The facility's plan of correction for a deficiency regarding developing comprehensive care plans, cited during the survey ending April 10, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding the development of comprehensive care plans. The facility's plan of correction for a deficiency regarding a failure to update residents' care plans, cited during the survey ending April 10, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding updating residents' care plans. The facility's plans of correction for deficiencies regarding ensuring that the residents' environment remained free from accident hazards, cited during surveys ending July 27, 2023, and April 10, 2024, revealed that audits would be completed. The results of the current survey, cited under F689, revealed that the QAPI committee was ineffective in correcting deficient practices related to ensuring that the residents' environment remained free from accident hazards. Cross refer to F558, F656, F657, F689. (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42079 Based on review of established infection control guidelines 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 one of 40 residents reviewed (Residents 17). Findings include: CDC guidance on isolation precautions for MRSA residents contained in Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated July 12, 2022, indicates that multidrug-resistant organism (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. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 17, dated May 13, 2024, revealed that the resident was clearly understood and could understand others, required assistance with care needs, and had a catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder). A care plan for Resident 17 regarding enhanced barrier precautions, dated April 30, 2024, revealed that the resident had EPB in place due to MDRO history and foley placement. Physician's orders for Resident 17, dated May 1, 2024, included an order for resident to receive enhanced barrier precautions due to foley catheter placement and history of MDRO every shift. Physician's orders for Resident 17, dated November 17, 2023, included orders to provide irrigation with 250 milliliters (ml) of normal saline as needed for leakage and blockage of the catheter. Observations of Resident 17 on June 24, 2024, at 12:47 p.m. revealed that the resident had signage at the entrance to her room to indicate that infection control measures for EBP were in place related to her catheter. Nurse Aide 7 was wearing gloves while draining the tea-colored catheter bag into a cylinder, then entered the bathroom. Nurse Aide 7 was not wearing a gown during the task of emptying the catheter bag. Interview with Nurse Aide 7 at the time of observations revealed that she only needed to wear a gown when providing care; however, Resident 17 was on enhanced precautions because she had a catheter. Interview with the Director of Nursing on June 27, 2024, at 1:18 p.m. confirmed that Resident 17 had EBP, and staff should have been wearing a gown to empty the catheter bag. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.		