

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/24/2024
NAME OF PROVIDER OR SUPPLIER  Majestic Oaks Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  333 Newtown Road Warminster, PA 18974	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>06525</p> <p>Based on clinical record review, interviews with staff, hospital record reviews and reviews of policies and procedures, it was determined that the facility failed to ensure that the physician was notified of a refusal of a laxative medication for one of four residents reviewed. (Resident R4)</p> <p>Findings include:</p> <p>Review of the facility policy titled refusal and/or discontinuing care or treatment dated February, 2021 revealed that it was the facility's responsibility to inform each resident of the care that will be furnished or made available to the resident based on his or her assessment and plan of care, the risks and benefits of the proposed care, treatment, treatment alternatives or treatment options and any changes in the resident's care plan. The policy indicated that if a resident refuses treatment, the staff would meet with the resident to determine why he or she is requesting, refusing or discontinuing care and treatment and address the resident's concerns, and offer alternative treatment and care options. The staff were also responsible to discuss the potential outcomes or consequences of the decision to refuse treatment. The detailed information related to refusal of care was to be documented in the resident's clinical record. The policy also said that the health care provided must be notified of any refusal of treatment or care in a timely manner.</p> <p>Review of Resident R4's clinical record review revealed a quarterly Minimum Data Set (resident assessment of care needs) dated February 9, 2024 which indicated that the resident was cognitively intact. The assessment also indicated that this resident was always incontinent of bowel.</p> <p>Review of Resident R4's March and April 2024's Medication Administration Records revealed orders for a bowel protocol to include administration of the laxative medication Miralax every 12 hours for treatment of constipation.</p> <p>Clinical record review revealed that the resident was refusing the bowel protocol as ordered by the physician to prevent constipation and promote healthy gastrointestinal functions. There was no documentation to indicate that the facility had notified the physician of the continuous medication refusals of care dated March 2, 8, 10, 11, 12, 16, 22, 23, 26, 27, 28, and 30. There was no documentation to indicate that the physician was notified of the repeated medication refusals on April 2, 3, 4, 5, 6, 7, 8, 2024.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of hospital documentation revealed that the resident was admitted to the hospital on April 8, 2024 for abdominal pain, nausea and vomiting with report of coffee-ground emesis prior to arrival. A scan of the abdomen showed no acute pathology but did demonstrate moderate to large stool burden and constipation.</p> <p>Hospital record review for Resident R4 for April 15, 2024 revealed that this resident was admitted to the hospital again with nausea, poor appetite, vomiting with coffee-ground emesis. A diagnostic imaging report at the hospital revealed moderate amount of stool within the colon.</p> <p>Interview with the Director of Nursing, Employee E2, at 3:00 p.m., on April 22, 2024 confirmed the physician was not informed of the resident's routine medication refusals for bowel treatment and prevention of constipation.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p> <p>28 Pa. Code 211.10(a)(b)(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>06525</p> <p>Based on clinical record review, hospital record review, interviews with staff and review of policies and procedure, it was determined that the facility failed to ensure that a benzodiazepine medication was administered as ordered by the physician which resulted in actual harm to Resident R3, who experienced a tonic clonic seizure and was diagnosed with a closed head injury and left frontal scalp hematoma for one of four residents reviewed. (Resident R3)</p> <p>Findings include:</p> <p>Review of the facility policy and procedure titled Medication Administration dated April, 2007, revealed that it was the responsibility of the licensed professional to document all medications administered to each resident as prescribed by the physician. The policy also stated that a signature and title of the person administering the medication was required to be documented on the medication administration record of the clinical record for each resident.</p> <p>Review of Resident R3's physician note dated February 8, 2024, indicated that the resident was under hospice care for protein calorie malnutrition. The physician also indicated that this resident had diagnoses of seizure disorder (a sudden, uncontrolled burst of electrical activity in the brain. It can cause changes in behavior, movements, feelings, and levels of consciousness)/ epilepsy (a neurological disorder characterized by recurrent epileptic seizures. These seizures result from abnormal, excessive, and synchronized electrical discharges in the neurons of the brain) and anxiety disorder.</p> <p>Review of hospice physician orders revealed an order for Lorazepam (Ativan) 2 mg by mouth every 15 minutes as needed for seizures; give 1mg Lorazepam orally every 15 minutes as needed for seizure activity and until seizure activity had stopped times four doses.</p> <p>Review of Resident R3's care plan initiated on December 15, 2022, revealed that care plan was developed related to the resident being at risk for seizures. The interventions included to administer the as needed medication Ativan with seizure activity. Continued review of Resident R3's care plan indicated that this resident had an alteration in neurological status. The approach listed on the care plan for alteration in neurological status was to give the medications as ordered by the physician to treat the resident's neurological disorder.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R3's physician's progress note dated March 1, 2024, revealed that the resident was admitted to the hospital emergently on February 25, 2024 for a witnessed collapse and onset of a tonic clonic seizure. Resident R3 had head trauma with the seizure activity and collapse. The physician indicated that an electroencephalogram of the brain was performed at the hospital and was remarkable for diffuse slow wave activity. The physician's progress note also indicated that prescribed as needed medication Diazepam (a medication used to treat epilepticus) rectally for seizure activity was not administered to Resident R3 at the seizure onset. Continued review of the physician progress note revealed that the resident was missing at least two doses of scheduled Lorazepam on February 24, 2024 and February 25, 2024 prior to the onset of the seizure activity. The physician indicated that the omission of medication for Resident R3 prior to seizure onset contributed to the seizure activity experienced by this resident on February 25, 2024. The physician noted that the root cause of the seizure and fall was due to benzodiazepine withdrawal symptoms shown by Resident R3 on February 25, 2024.</p> <p>Review of Resident R3's February 2024, Medication Administration Record (MAR) confirmed that the resident was to be administered Lorazepam 2 milligrams (mg) by mouth every 6 hours daily at midnight; 6:00 a.m.; 12:00 p.m. and 6:00 p.m. and 12:00 a.m. Continued review of the MAR revealed that on February 24, 2024 the 12:00 a.m. and 6:00 a.m. dose was coded 5 (hold/see nurses notes). The 12:00 p.m. dose was administered and there was no documented evidence that the 6:00 p.m. dose was administered. On February 25, 2024 the 12:00 a.m. and 6:00 a.m. dose was again coded 5 hold/see nurses notes.</p> <p>Review of nursing notes for the entire month of February 2024, revealed no documentation related to the omission of the medication Lorazepam.</p> <p>Review of nursing note dated February 25, 2024, indicated that Resident R3 was being assisted with eating while the resident was sitting down. Resident R3 jumped up and began seizure for three to five seconds. Resident R3 then fell and hit his head. Resident appeared alert, pupils were responsive to light. Vital signs and neurological checks were within normal limits. Resident R3 was found to have a large hematoma to the left forehead.</p> <p>Review of Resident R3's hospital documentation confirmed that Resident R3 was admitted to the hospital on February 25, 2024, as a trauma alert and was diagnosed with a closed head injury (left frontal scalp hematoma).</p> <p>Interview with the Director of Nursing, Employee E2, on April 22, 2024, at 2:00 p.m., confirmed that the medications Lorazepam were not given as prescribed by the physician for Resident R3 on February 24, 2024 and February 25, 2024. Further interview with the Director of Nursing, Employee E2 on April 24, 2024, at 11:00 a.m., confirmed that Resident R3 had a tonic clonic seizure on February 25, 2024 and sustained a fall and head trauma; after medications used to treat seizure disorder and anxiety disorder were omitted from administration by the nursing staff on February 24, 2024 and February 25, 2024, causing Resident R3 to experience symptoms of Lorazepam withdrawal (grand mal seizure).</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management</p> <p>28 Pa. Code 211.10(a)(b)(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	28 Pa. Code 211.9(a)(1)(b) Pharmacy services  28 Pa. Code 211.5(f)(iii)(vii)(ix)(x) Medical records

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 06525</p> <p>Based on clinical record review reviews of policies and procedures and interviews with residents and staff, it was determined that the facility failed to address the behavioral health needs and services for one of two residents. (Resident R1)</p> <p>Findings include:</p> <p>Review of the policy titled behavioral health services dated February, 2029 revealed that it was the responsibility of the facility to provide behavioral health services for each resident to maintain their highest practicable physical, mental and psychosocial well-being. The policy indicated that residents having emotional or psychosocial distress would receive services to meet their needs. The policy also indicated that residents having diagnoses of mental, psychiatric or psychosocial adjustment disorders would receive services to meet their needs. The policy said that residents with substance abuse or post traumatic stress disorder would receive services to promote dignity, autonomy, privacy, socialization and safety.</p> <p>The policy titled comprehensive person-centered care plans dated March, 2022 indicated that the facility was responsible for developing and implementing a comprehensive care plan for each resident with measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The policy also indicated that the care plan was to include services and care that will be furnished for the resident by the facility to maintain his/her highest practicable physical, mental and psychosocial well-being.</p> <p>Review of Resident R1's annual comprehensive Minimum Data Set (MDS-an assessment of care needs) dated February 29, 2024 revealed that Resident R1 was admitted to the facility on [DATE]. The assessment indicated that this resident was cognitively intact. The resident indicated in this assessment that it was very important to him to choose his daily routine for activities of daily living including recreational activities. The assessment indicated that Resident R1 had no physical impairments of the upper extremities but that both lower extremities were impaired. The assessment indicated that Resident R1 was incontinent of bowel and bladder and that intermittent catheterization was required for bowel and bladder care. The assessment indicated that Resident R1 had diagnoses of paraplegia, bipolar disorder and post traumatic stress disorder. The Resident R1 was prescribed antipsychotic and antianxiety medications.</p> <p>Review of Resident R1's psychiatrist note dated March 27, 2024 revealed that Resident R1 was feeling irritable with staff. The resident said that interactions with staff were causing feelings of anxiety. The psychiatrist indicated that Resident R1 spoke extensively about not wanting to be at the facility, because the resident was not able to be with his children. The psychiatrist indicated that Resident R1 had adjustment disorder, anxiety disorder, bipolar disorder and post traumatic stress disorder.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Clinical record review revealed a nursing progress note dated April 1, 2024 that indicated Resident R1 was irritated with nursing staff saying that a nursing assistant was stealing his soiled clothes. The nursing progress note indicated that it was two nursing assistants especially, that Resident R1 did not want in his bed room.</p> <p>Review of psychiatrist note dated April 8, 2024 indicated that Resident R1 was verbally aggressive with nursing staff.</p> <p>Clinical record review revealed a nursing progress note dated April 10, 2024 that indicated Resident R1 was reporting that he did not like his assigned nursing assistant.</p> <p>Interview with Resident R1 at 10:30 a.m., on April 22, 2024 revealed that he had asked staff to assist him on many occasions with discharge planning back to the community. Resident R1 said that he wants to be present with his children. The resident also mentioned that some of the nursing staff do not respect his privacy, dignity or autonomy. Resident R1 said that he has a routine that he would like to keep on a daily basis for activities of daily living. Resident R1 reported that the nursing staff members that he is not fond come into his room to tell him what to do and when to do it. Resident R1 admitted to using foul language and in the past a verbal threat toward staff to get them to leave him alone; until he is ready for them to assist with his care needs. Resident R1 also reported during this interview that he had been asking the social work staff for months to help him get a motorized wheel chair.</p> <p>Review of social services notes dated August 20, 2023 indicating that Resident R1 was asking the social worker to help him with discharge plans back to the community. A social service progress note dated January 31, 2024 that indicated Resident R1 was requesting the assistance of the facility with the Nursing Home Transitions Program so that the resident was able to find housing and transition back into the community. Review of Resident R1's clinical record revealed no documentation to indicate the resident had been assisted with discharge planning.</p> <p>Interview with the Director of Nursing, Employee E2 and Social Worker, Employee E3, at 11: 00 a.m., on April 22, 2024 confirmed that there was no care plan developed and implemented for discharge planning for Resident R1.</p> <p>Clinical record review for Resident R1 revealed that there was no documentation that Resident R1 was assisted with his behavioral health needs related to the diagnosis of paraplegia. The resident was asking for assistance to obtain a electric or motorized wheel chair to assist with his mobility needs.</p> <p>Interview with the Director of Nursing, Employee E2 and the Social Worker, Employee E3 at 1:00 p.m., on April 22, 2024 confirmed that there was evidence that Resident R1 behavioral health needs of anxiety, irritability, loneliness, depression, threatening behavior, angry outbursts were addressed and/or care plan.</p> <p>28 Pa. Code 211.10(a)(b)(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p>		