

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  05/28/2024
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 - 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48347</p> <p>Based on facility policies, clinical record review and staff interviews, it was determined that the facility failed to communicate to the resident's physician assistant the refusal of a prophylactic anticoagulant medication for one of eight residents reviewed. This failure resulted in actual harm to Resident R86 who missed nine doses of an anticoagulant medication and development of Deep Venous Thrombosis. (Resident R86)</p> <p>Findings include:</p> <p>Review of facility policy titled Documentation of Medication Administration dated October 20, 2023, revealed that A nurse shall document all medications administered to each resident on the resident's medication administration record (MAR). Documentation must include, as minimum: name and strength of drug, dosage, method of administration, date and time of administration, reasons why a medication was withheld, not administered, or refused, and signature and title of person administering the medication.</p> <p>Review of facility policy titled Requesting, Refusing and /or Discontinuing Care or Treatment revealed a resident and resident representatives have the right to request and or discontinue treatment. Treatment refers to medical care, nursing care, and interventions provided to maintain or restore health and wellbeing, improve functional level and improve symptoms.</p> <p>Continued review of this policy states that If a resident / representative requests, discontinues or refuses care of treatment, an appropriate member of the interdisciplinary team with meet with the resident / representative to determine why he or she is requesting, refusing, or discontinuing care or treatment. The interdisciplinary team will try to address his or her concerns and discuss alternative options and discuss potential outcome or consequences of the decision. The decision to refuse or discontinue treatment results in a significant change of condition, a reassessment will occur, and appropriate changes will be made to the resident's care plan. Detailed information relating to the requests, refusal or discontinuation of treatment are documented in the resident's medical record. Documentation must include date and time, residents' response, the date, and time the practitioner was notified as well as the practitioner's response.</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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F 0580  Level of Harm - Actual harm  Residents Affected - Few	<p>Review of Resident R 86's clinical record revealed that Resident R86 was admitted to facility on August 30, 2021. This resident has a diagnosis of fracture of neck of left femur (left hip fracture), vascular dementia (decreased blood flow to brain tissue causing memory problems), atherosclerotic heart disease (hardening of arteries), unspecified hearing loss, bilateral hearing loss of both ears), anxiety disorder (mental disorder characterized by excessive uncontrollable feeling of worry and fear).</p> <p>Review of Resident R86's significant change Minimum Data Set (MDS-a federal mandated assessment used to summarize residents' health status) assessment dated [DATE], revealed that the resident had a BIMS (Brief Interview for mental status) of 99 which indicated that this resident was unable to complete the assessment. The resident was assessed by the staff with short and long term memory impairment.</p> <p>Continued review of Resident R86's clinical record exposed that Resident R86 sustained a fall January 9, 2024, resulting in a left hip fracture. This resident was hospitalized and discharged back to the facility January 12, 2023.</p> <p>Review of Resident R86's hospital discharge documentation dated January 12, 2024, reveled that during the hospital stay Resident R86 underwent surgery, operative fixation of intertrochanteric hip fracture. Further review of this hospital document revealed that Resident R86 was prescribed Enoxaparin (Lovenox) an anticoagulant, 30mg/0.3 ml to be injected every twenty-four hours for one month to reduce the chance of blood clots following surgery.</p> <p>Review of Resident R86's January 2024, physician orders revealed that an order was obtained on January 12, 2024, for Enoxaparin sodium injection solution prefilled syringe 30 (milligrams) mg/0.3 ml, inject 0.3 ml subcutaneously one time a day for hip fracture.</p> <p>Review of physician note dated February 12, 2024, by Employee E19 who was Resident R86's medical practitioner stated that Resident R86 was being seen for exam, nursing notes noted that this resident was assessed with left lower edema (swelling). Patient noted with pain and swelling, unable to wear shoe on left foot. On review of patient's chart, it appears patient has not had Lovenox (Enoxaparin) for the last three days and was also not administered on February 5, 2024, February 7, 2024 and February 9, 2024, it is unclear why she has not received the medication, whether to refusal or other reason. Employee E19 gave orders to obtain a venous doppler (a special ultrasound that evaluates blood flow) to rule out a DVT (deep vein thrombosis, blot clot usually found in the legs that can travel through the bloodstream to heart of lungs causing a life-threatening complication) given pain, swelling, warmth, and reduced peripheral pulses. Order to continue the Lovenox(Enoxaparin).</p> <p>Review of Resident R86's doppler scan result completed on February 16, 2024, reported on February 20, 2024, concluded that the Left lower extremity venous ultrasound including Doppler with result of positive for segment of thrombus in the anterior tibial vein.</p> <p>Review of Resident R86's February 2024 Medication Administration Record (MAR) revealed that Resident R86 had missed 9 doses of the blood clot prophylactic medication Lovenox (Enoxaparin). The code number (2) was documented on the February 2024 MAR for refused: February 5, 2024, February 7, 2024, February 9, 2024, February 10, 2024, February 11, 2024, February 18, 2024, and February 19, 2024. There was no documentation on the MAR related to the administration of the Lovenox on February 13, 2024, and February 16, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Licensed nurse, Employee E5 on May 24, 2024, at 9:45 a.m. revealed that this employee was educated and trained of the facility policy of medication refusal. Licensed nurse, Employee E5 described that is it the facility protocol that when a resident refuses medication must be documented, notifies the doctor, and notify the family. Licensed nurse, Employee E5 confirmed that this employee did not administer the prophylactic medication Lovenox to Resident R86 on numerous days because the resident refused. Licensed nurse, Employee E5 reported that the resident seems fearful of the injection by displaying restlessness and screaming when attempting to administer the injection. Licensed nurse, employee E5 confirmed that she did not administer the medication and did not document why it was not given. Employee E5 stated that the refusal was reported verbally to the medical doctor and the family but neglected to document the notifications.</p> <p>Interview with former medical practitioner, Employee E19 on May 23, 2024, at 2:00 p.m. confirmed that she was employed at the facility as a physician assistant and treated Resident R 86. Employee E19 conveyed that this employee was never made aware of the refusal until after the resident was assessed with sign and symptoms of a possible DVT (Deep Vein Thrombosis- blood clot). Employee E19 stated that the refusals were never discussed with her; it was not until she reviewed the resident's record and noticed that the medication has not been given. After receiving in the ultrasound result, the resident was ordered an oral blood thinner Eliquis.</p> <p>The facility failed to communicate to Resident R86's former medical practitioner, Employee E 19 that the resident was refusing the prophylactic anticoagulant medication, which resulted in the resident missing 9 doses of Lovenox. This failure resulted in actual harm to Resident R86 who development of Deep Venous Thrombosis.</p> <p>28 Pa Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 211.10 (c) Resident care policies</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3) Nursing services</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>43277</p> <p>Based on observations, review of facility policy and staff and resident interviews, it was determined that the facility failed to maintain a clean and homelike environment in the main dining room and two of three nursing units (Second floor and Third Floor).</p> <p>Findings Include:</p> <p>Review of facility policy titled Bath, Shower, Tub revised February 2018 revealed the purpose of the procedures are to promote cleanliness, provide comfort to the resident and observe skin conditions.</p> <p>This policy included instructions including: to be sure the tub or shower is clean, the bath area is a comfortable temperature for the resident, if using a shower regulate the temp and the flow of the water warm water is 105 degrees Fahrenheit.</p> <p>Observation on May 21, 2024, at 11:00 a.m., accompanied with Nursing Home Administrator Employee E1 (NHA), Director of Nursing, Employee 2 and Maintenance Director, Employee E11 of Third floor's resident shower, displayed a deteriorated malfunctioning shower. The shower floor was observed with noticeable fragmented broken concrete, sharp, shattered pieces. The showers wall was moldered, and drain was missing a cover leaving a large opening in the floor. Interview with NHA Employee E1 at time of observation revealed that Employee 1 and Employee 14 were aware of the damaged shower floor. Employee E1 stated that administration and staff strongly suggest to residents to use available showers on alternate floors.</p> <p>Further observation of the shower on the Third floor revealed that the shower temperature was not an appropriate temperature for bathing water. Maintenance director, Employee E 14 obtained the working temperature of the shower water by a handheld thermometer, the thermometer on the shower wall did not function properly. Employee E14 reported that the water temperature ranged from 76 degrees Fahrenheit to 77.5 degrees Fahrenheit after ten minutes of continuously running water. The ideal temperature for bath is 98 degrees to 105 degrees.</p> <p>Continued observation of the shower revealed a large amount of water collecting on the floor of the shower. The shower drain appeared inoperable. The pooling of water on the shower floor required Employee E14 need to plunge the drain for the water to drain properly.</p> <p>Interview with the following residents, all whom reside on the third floor and have been showering in the third-floor shower room.</p> <p>Interview with Resident R19 on May 22, 2024, 9:15 a.m. revealed that he continually has requested using the shower but has not been able for three weeks, this resident was told shower does not work.</p> <p>Interview with Resident R71 on May 22,2024 10:25 a.m. stated that he uses the shower admits that you need to be really careful, and watch wear you step, the floor is broken resident continues to report the water is cold. Resident R71 stated it is too inconvenient to go to another floor.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Resident R23 May 22, 2024, at 9:55 a.m stated that you need to take you time and watch your step and water is too cold. Resident R23 has not been offered a shower on another floor.</p> <p>Interview with Resident R29 May 23, 2023, 10:10a.m. stated I won't use the shower because it is broken therefore the resident stated that he has been utilizing the sink in his room to wash himself. Resident R29 reported that he has not been offered to shower on another floor.</p> <p>Interview with Resident R56 on May 23, 2024, at 10:35 a.m. stated that this resident has not been offered a shower on another floor.</p> <p>Resident R 5 May 23, 2024, 12:55 p.m has utilized the shower and reported that the floor is all chopped up, This resident stated that she was not offered a shower on another floor, and the aides do not like going to other floors.</p> <p>Observations on May 21, 2024, at 11:58 a.m. on the Second floor nursing unit revealed a utility cart placed in front of the dining room and seen when coming off the elevator, with leftover breakfast trays with food and beverages still on the trays. Subsequent interview on May 21, 2024, at 12:00 p.m. with Registered Nurse, Employee E10, confirmed leftover breakfast trays were not cleaned up as the lunch meal service was getting ready to start.</p> <p>Observations on May 24 ,2024, at 9:45 a.m. in the main dining room where residents congregate for meal services on the 1st floor, revealed a broken cabinet used for the storing of items. Interview on May 24, 2024, at 9:45 a.m. with the Food Service Director, Employee E18, confirmed broken cabinet in the main dining room.</p> <p>28 Pa. Code 201.14 Responsibility of licensee</p> <p>28 Pa. Code 210.18 (2.1) Management</p> <p>28 Pa. Code 204.9 (a) Bathing facilities</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>38947</p> <p>Based on staff interviews, review of facility policy and the review of the clinical record, it was determined that the facility failed to ensure that a complete and thorough investigation was conducted to rule out abuse/neglect for a bruise of an unknown original for 1 out of 30 residents reviewed (Resident R39)</p> <p>Findings include:</p> <p>Review of the facility policy, Abuse and Neglect-Clinical Protocol with a revised date of March 2018, indicated that management and staff with physician support will address situation of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. Continued review of the policy indicated that if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The policy also indicated that upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or</p> <p>injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents.</p> <p>Review of the Resident 39's May 2024 physician orders included the diagnoses of hypertension (high blood pressure); cerebral infarction (a stroke); contracted right elbow and right wrist; dysphagia (difficulty swallowing) and congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply).</p> <p>Review of the resident's Annual Minimum Data Set Assessment (MDS- a periodic assessment of a resident's needs) dated April 26, 2024, indicated that the resident was cognitively impaired.</p> <p>Review of a clinical note written by the resident's nurse practitioner (Employee E21) on May 13, 2024, at 6:30 a.m. indicated that Resident R39 requested that she come to her room, reported pain in her left forearm. The nurse practitioner also reported that she noticed a large bruise to the resident's forearm. The patient requested a visit, by flagging me to come into her room. She reports pain in her left forearm. There is a large bruise to her left forearm</p> <p>Continued review of the note from the nurse practitioner indicated that she followed up with nursing staff after her visit. I discussed the case with nursing.</p> <p>Review of the resident's nursing notes and clinical record did not show any follow up documentation or assessments from nursing staff indicating that they were aware of the bruise that was identified by the nurse practitioner on May 13, 20024 during her examination of the resident.</p> <p>During an interview with the Third floor Unit Manager (Employee E13) on May 24, 2024, at 12:40 p.m. Employee E13 reported that she was not aware of the above referenced bruise found on Resident R39 by the nurse practitioner, and that there was no investigation conducted by the facility regarding the bruise.</p> <p>(continued on next page)</p>		

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F 0610  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa. Code 201.18(b)(1)(3) Management  28 Pa. Code 211.10(d) Resident care policies  28 Pa. Code 211.12(c) Nursing services

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</b></p> <p>Based on observations, review of clinical records and staff interviews, it was determined that the facility failed to develop and implement an individualized, comprehensive care plan with measurable objectives and interventions to meet the resident's needs for one of 30 residents reviewed (Resident R140).</p> <p>Findings Include:</p> <p>Review of Resident R140's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated May 14, 2024, revealed the resident had moderate cognitive impairment, and functional limitation in range of motion to upper and lower extremities. Further review of the MDS revealed Resident R140 had diagnoses of hemiplegia (one-sided paralysis or weakness), muscle weakness, and need for assistance with personal care.</p> <p>Continued review of Resident R140's quarterly MDS dated [DATE], revealed the resident required substantial/maximal assistance (helper does more than half the effort) with personal care.</p> <p>Review of Resident R140's comprehensive care plan revised February 16, 2024, revealed the resident was at risk for alterations in skin related to weakness. Intervention dated May 16, 2024, included to apply resting hand splint to left hand daily at bedtime.</p> <p>Further review of Resident R140's comprehensive care plan revised December 27, 2023, revealed the resident had an activities of daily living self-care performance deficit related to activity intolerance, confusion, and hemiplegia.</p> <p>Observations on May 22, 2024, at 9:47 a.m. revealed Resident R140 had a contracture of the left hand. Further observations revealed Resident R140 had significant long, and dirty, fingernails on the left hand, however the right-hand nails were trimmed and clean.</p> <p>Interview on May 22, 2024, at 10:02 a.m. with nurse aide, Employee E8, confirmed Resident R140's left hand nails required trimming. Further interview with nurse aide, Employee E8, revealed Resident R140 has pain to the left hand and may be the reason the resident does not allow staff to trim nails on that side.</p> <p>Observations on May 28, 2024, at 9:48 a.m. with Registered Nurse, Employee E10, revealed Resident R140's nails were trimmed shorter, yet still long enough to inflict self-injury. When Registered Nurse, Employee E10, tried to open Resident R140's left hand to make observations of the nails and inside of the palm, Resident R140 was visibly guarded of the left hand and hesitant to comply.</p> <p>Subsequent interview on May 28, 2024, at 9:48 a.m. with Registered Nurse, Employee E10, confirmed Resident R140 had a history of refusing care, including refusal of nail care and refusal to wear splint to the left hand. Further interview with Registered Nurse, Employee E10, confirmed Resident R140 is at an increased risk of skin breakdown to the palm of the left hand due to refusal of nail care and left-hand contracture.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R140's comprehensive care plan revealed no documented evidence a plan of care was developed related to Resident R140's behaviors of refusing care and measurable objectives and interventions to meet Resident R140's needs related to refusal of nail care, refusal of hand splint, and left-hand contracture.</p> <p>28 Pa. Code 211.10 (d) Resident Care Policies</p> <p>28 Pa. Code 211.12 (d)(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 - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>38947</p> <p>Based on observations, review of facility policy, staff interviews and the review of the clinical record, it was determined that the facility did not ensure that services provided met professional standards of practice in regard to a change in a resident's medical condition for 1 out of 30 residents reviewed (Resident R39).</p> <p>Findings include:</p> <p>Review of the facility policy, Change in a Resident's Condition or Status, with a revision date of April 2024 indicated that the facility promptly notifies the resident, his or her attending physician, and the resident's representative of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing payments, resident rights, etc.).</p> <p>Review of the policy also included the following situations in which nursing will notify the resident's attending physician or the physician on call of resident changes: an accident or incident involving the resident; discovery of injuries of an unknown source; refusal of treatment; specific instructions from the physician to notify him/her about changes in a resident's condition, or significant changes in the resident's physical/emotional/mental condition.</p> <p>Review of the Resident 39's May 2024 physician orders included the diagnoses of hypertension (high blood pressure); cerebral infarction (a stroke); contracted right elbow and right wrist; dysphagia (difficulty swallowing) and congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply).</p> <p>Review of a nursing note dated August 11, 2023, at 6:32 p.m. indicated that the resident vomited a large amount of coffee ground emesis (vomit that looks like coffee grounds and is a sign of internal bleeding in the upper gastrointestinal tract). Continued review of the nursing note indicated that the physician was contacted by the charge nurse (Employee E28) regarding the above referenced incident, and that the facility was awaiting a phone call back from the physician.</p> <p>Resident vomited x1 large amount of coffee ground emesis .A call was placed to PCP regarding resident status, awaiting PCP's response</p> <p>Continued review of the resident's nursing notes did not show evidence that the physician called back and what, if anything, did the physician order the staff upon receiving the report of the resident vomiting coffee ground emesis,</p> <p>During an interview with the 3rd floor Unit Manger (Employee E13) on May 24, 2024 at 10:45 a.m. it was discussed that there was no documentation that there was any follow up contact with the physician regarding the message left by the charge nurse related to a change in the resident's medical condition.</p> <p>28 Pa Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 211.10 (c) Resident care policies</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 - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>43277</p> <p>Based on review of clinical records, observations, and staff interview, it was determined that the facility failed to ensure interventions were implemented for the prevention of pressure ulcers for one of five residents reviewed for pressure ulcers (Resident R1).</p> <p>Findings Include:</p> <p>Review of Resident R1's Quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated April 25, 2024, revealed the resident was cognitively impaired and had diagnoses of diabetes mellitus (disorder of carbohydrate metabolism) and hemiplegia (one-sided paralysis or weakness).</p> <p>Review of Resident R1's comprehensive care plan revised on January 22, 2024, revealed the resident was at risk for developing wounds related to non-compliance with care. Intervention dated February 16, 2024, included to offload heels as ordered.</p> <p>Review of Resident R1's clinical record revealed a physician order dated February 23, 2024, to apply heel boots (device that pads the heel to relieve pressure and help to prevent skin breakdown) while in bed every shift.</p> <p>Observations on May 22, 2024, at 10:16 a.m. with nurse aide, Employee E8, revealed Resident R1 was laying in bed and was not wearing the heel boots as ordered. Further observations with nurse aide, Employee E8, revealed there were no heel boots in the room to apply for Resident R1.</p> <p>Interview on May 22, 2024, at 10:20 a.m. with licensed nurse, Employee E20, confirmed Resident R1 had a treatment order for heel boots while in bed and was unsure why the boots were not applied for Resident R1.</p> <p>Follow-up observations on May 22, 2024, at 12:15 pm. revealed Resident R1 was still in bed without heel boots applied.</p> <p>Review of Resident R1's entire clinical record revealed no documented evidence Resident R1 refused to wear heel boots.</p> <p>28 Pa. Code 211.10 (d) Resident Care Policies</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services</p>		

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NAME OF PROVIDER OR SUPPLIER  Majestic Oaks Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  333 Newtown Road Warminster, PA 18974	
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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>38947</p> <p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on observations, staff interviews, and review of clinical records, it was determined that the facility failed to ensure that weekly weights were obtained for 2 out of 30 residents reviewed with a history of weight loss (Resident R39 and Resident R454).</p> <p>Findings include:</p> <p>Review of the Resident R39's May 2024 physician orders included the diagnoses of hypertension (high blood pressure); cerebral infarction (a stroke); contracted right elbow and right wrist; dysphagia (difficulty swallowing) and congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply).</p> <p>Review of the nutritional note by the Registered Dietician dated November 15, 2023, at 3:51 p.m. indicated that Resident R39 experienced an 18.3% significant weight loss from</p> <p>October 2, 2023 (weight recorded as 167 pounds) through November 9, 2023 (weight recorded as 136.4). Resident also had a significant weight loss over the past three months of</p> <p>-19.3% with August 2, 2023 weight recorded as 169 pounds; September 13, 2023 weight recorded as 164 pounds; October 2, 2023 weight recorded as 167 pounds and November 9, 2023 weight recorded as 136.4 pounds.</p> <p>Continued review of the nutritional notes indicated that the resident was at increased risk for malnutrition (a condition that develops when the body is deprived of vitamins, minerals and other nutrients it needs) due to the weight loss. Rt (resident) noted with significant, unfavorable and unplanned weight loss</p> <p>Review of the physician orders for November 2023 included a physician order with a start date of November 21, 2023, for the resident to have weekly weights taken one time a week on Tuesdays for 4 weeks. Weight monitoring for recent significant weight change for 4 weeks. The end date for the order was documented as December 19, 2023.</p> <p>Review of the resident's weights record revealed no documented evidence that the nursing staff obtained weekly weights as ordered by the physician, for the time period requested.</p> <p>During an interview with the 3rd floor Unit Manager (Employee E13) on May 24, 2024, at 10:45 a.m. it was discussed that there was no evidence in the clinical record that weekly weights were obtained for Resident R39, as ordered.</p> <p>Review of the May 2024 physician order for Resident R454 included the diagnoses of Chronic obstructive pulmonary disease (COPD), dementia (a group of symptoms that affects memory, thinking and interferes with daily life); hypertension (high blood pressure) and deep vein thrombosis (blood clots).</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 the resident's nutritional note by the facility's dietician dated February 14, 2024, at 10:48 a.m. documented a significant, unplanned weight loss for the resident of -8%. The nutritional note indicated that the resident's weight recorded on February 13, 2024 was 131.5 pounds, and that the recorded body of weight of the resident on January 31, 2024 was 143 pounds.</p> <p>Review of the physician orders for February 2024 included a physician's order with a start date of February 20, 2024, for the resident to have weekly weights taken one time a week on Tuesdays for 4 weeks. Weight monitoring for recent significant weight change for 4 weeks. The end date for the order was documented as March 19, 2024.</p> <p>Review of the resident's recorded weights did not show evidence that the nursing staff obtained any weekly weights as ordered for the time period requested. Review of a nursing note dated February 27, 2024 at 11:17 a.m. indicated that the scale was not available. Weighting machine not available. Review of a nursing note on March 12, 2024 at 3:01 documented that the scale was not working. Weight machine malfunctioned.</p> <p>During an interview with the 4th floor Unit Manager (Employee E26) on May 24, 2024, at 2:20 p.m. confirmed that the weekly weights ordered for the resident were not obtained, and that the scale on the 4th floor where the resident resided was not working properly for them to be obtained.</p> <p>28 Pa. Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(3) Nursing services</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36609</p> <p>Based on observation, staff interviews, review of clinical records and review of facility policy, it was determined that the facility failed to ensure that medications were delivered from pharmacy timely for two of 30 resident records reviewed (Resident R133 and Resident R39).</p> <p>Findings include:</p> <p>Review of facility policy titled Pharmacy Services Overview revised April 2029 states, The facility shall accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals.</p> <p>Resident R133 was initially admitted to the facility on [DATE], diagnosed with chronic pancreatitis (pancreatis does not produce enzymes or hormones to ensure proper digestion to absorb nutrients) and Tinea Cruris (fungal infection).</p> <p>Review of Resident R133's physician orders revealed an order for Pancrelipase (Lip-Prot-Amyl) Capsule, delayed release particles 12000-38000 UNI (used to help improve food digestion) was instructed to give one capsule by mouth with meals for pancreatitis. Further review of the resident's clinical record revealed that during meal time on March 16, 17, 2024 and on April 4, 2024 the medication was not given as ordered due to On Order or Awaiting Rx (prescription) delivery.</p> <p>Further review of Resident R133's physician orders revealed Miconazole Nitrate Powder 2 % instructed to apply two times a day for fungal rash. Further review of the resident's clinical record revealed that on December 19, 2023, and February 18, 2024, the medicated powder was not apply due to either on order or waiting pharmacy delivery.</p> <p>This was confirmed with the Nursing Home Administrator on May 24, 2024, at 1:30 p.m.</p> <p>Review of the Resident's May 2024 physician orders for Resident R39 included the following diagnosis: hypertension (high blood pressure); cerebral infarction (a stroke); contracted right elbow and right wrist; dysphagia (difficulty swallowing) and congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give the body a normal supply).</p> <p>Review of a progress note from the nurse practitioner dated March 7, 2024 at 10:42 a.m. documented, The resident had a stringy light-yellow drainage in her left eye Continued review of the progress notes indicated that the resident was diagnosed with Viral Conjunctivitis (also known as pink eye, is a highly contagious type of eye infection caused by a virus). The nurse practitioner prescribed Ocusoft Lid Scrub Cleanser to be used twice a day for 7 days.</p> <p>Review of Resident R39's May 2024 physician orders included the diagnoses of hypertension (high blood pressure); cerebral infarction (a stroke); contracted right elbow and right wrist; dysphagia (difficulty swallowing) and congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a progress note from the nurse practitioner dated March 7, 2024, at 10:42 a.m. documented, The resident had a stringy light-yellow drainage in her left eye Continued review of the progress notes indicated that the resident was diagnosed with Viral Conjunctivitis (also known as pink eye, and a highly contagious type of eye infection caused by a virus). The nurse practitioner prescribed Ocusoft Lid Scrub Cleanser (an eyelid cleanser) to be administered to the resident every morning and at midnight for 7 days.</p> <p>Review of the March 2024 physician orders indicated an order for the medication, with a start date of March 7, 2024, at 10:43 a.m. The physician's order indicated that the treatment should be administered at 9:00 a.m. and 9:00 p.m. each day.</p> <p>Review of March 2024's Medication Administration Record (MAR) indicated that resident was not administered the treatment on the following dates and times:</p> <p>March 7, 2024 at 9:00 p.m. treatment was not administered. The box that corresponded with the above date and time was blank. There was no corresponding note to indicate why the treatment was not administered.</p> <p>March 8, 2024 at 9:00 a.m. treatment was not administered. The box that corresponded with the above date and time was blank. There was no corresponding note to indicate why the treatment was not administered.</p> <p>March 8, 2024 at 9:00 p.m. treatment was not administered. There was no corresponding note to indicate why the treatment was not administered.</p> <p>March 9, 2024 at 9:00 a.m. treatment was not administered and was documented on the MAR as being NP and is coded to mean NPO (a medical abbreviation indicating that someone should not receive fluids or solids by mouth) and to see order. There was no corresponding physician's order or nursing note indicating why the treatment was not administered.</p> <p>March 9, 2024 at 9:00 p.m. treatment was not administered and was documented on the MAR as being on hold. The corresponding nursing note documented on March 9, 2024, at 10:33 p.m. indicated that the facility was awaiting delivery of the medication from pharmacy.</p> <p>March 10, 2024 at 9:00 a.m. treatment was not administered and was documented on the MAR as being on hold. The corresponding nursing note documented on March 10, 2024, at 10:33 p.m. indicated that the facility was awaiting delivery of the medication from pharmacy.</p> <p>March 10, 2024 at 9:00 p.m. treatment was on the MAR as being on hold. The corresponding nursing note documented on March 9, 2024, at 10:33 p.m. indicated that the facility was awaiting delivery of the medication from pharmacy.</p> <p>March 11, 2024 9:00 a.m. treatment was not administered and was on the MAR as being on hold. There was no corresponding nursing note indicating why the medication was not administered.</p> <p>March 11, 2024 at 9:00 p.m. treatment was not administered and was on the MAR as being on hold. There was no corresponding nursing note indicating why the medication was not administered.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>March 12, 2024 at 9:00 a.m. treatment was not administered and was on the MAR as being on hold. The corresponding nursing note documented on March 12, 2024, at 11:54 a.m. indicated that the facility was awaiting delivery of the medication from pharmacy.</p> <p>March 12, 2024 at 9:00 p.m. treatment was not administered and was on the MAR as being on hold. The corresponding nursing note documented on March 12, 2024, at 9:30 p.m. indicated that the facility was awaiting delivery of the medication from pharmacy.</p> <p>March 13, 2024 at 9:00 a.m. treatment was not administered and was on the MAR as being on hold. There was no corresponding nursing note indicating why the medication was not administered.</p> <p>March 13, 2024 at 9:00 p.m. treatment was not administered and was on the MAR as being on hold. There was no corresponding nursing note indicating why the medication was not administered.</p> <p>March 14, 2024 at 9:00 a.m. treatment was not administered and was on the MAR as being on hold. There was no corresponding nursing note indicating why the medication was not administered.</p> <p>March 14, 2024 at 9:00 p.m. treatment was not administered and was on the MAR as being on hold. There was no corresponding nursing note indicating why the medication was not administered.</p> <p>Review of the MAR for the remaining days in March 2024 also revealed that the treatment was not being provided to the resident as ordered by the physician, due to the reasons listed above.</p> <p>Review of the resident's clinical record did not provide any information as to why the medication was not available from the pharmacy and administered to the resident for the treatment of her eye infection, as ordered. Review of the clinical record also did not show evidence of any documentation from nursing staff that the nurse practitioner and/or physician were notified that the resident was not receiving the treatment for her eye condition due to the medication not being available.</p> <p>During an interview with the Unit Manager (Employee E13) on May 28, 2024, at 12:18 p.m. it was discussed that the above referenced treatment was not administered to the resident, as ordered.</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy services</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12 (d)(1)(3) Nursing services</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36609</p> <p>Based on review of clinical records, interview with staff and review of facility policy, it was determined the facility failed to ensure that as needed psychotropic medication included an end date for stopping the medication for one of 30 resident records reviewed (Resident R25).</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Psychotropic Medication Use revised July 2022 states, Residents will not receive medications that are not clinically indicated to treat a specific condition. The policy defines psychotropic medication as any medication that affects brain activity associated with mental processes and behaviors. The same policy further states that psychotropic medications are not prescribed or given on a PRN (as needed) basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic medications are limited to 14 days. For psychotropic medications that are NOT antipsychotics (example the benzodiazepines lorazepam aka Ativan)if the physician believes it is appropriate to extend the PRN order beyond 14 days the physician will document the rationale for extending the use and included the duration for the PRN order.</p> <p>Review of Resident R25's clinical record revealed that the resident was admitted to the facility on [DATE], with the diagnoses of bipolar disorder, intermittent explosive disorder, anxiety, restlessness and agitation.</p> <p>Resident R25's physician order dated April 30, 2024, instructed one 0.5 mg tablet MG (Lorazepam) was to be given by mouth every 12 hours as needed for agitation &amp; anxiety in the afternoon to help combat moments of aggression at this time a day. Further review revealed no specific duration period for this medication.</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa code 211.12 (d)(1) Nursing Services</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43277</p> <p>Based on review of facility policy, review of clinical records, and staff interview, it was determined that the facility failed to ensure labs were completed per physician orders for one of 30 residents reviewed (Resident R118).</p> <p>Findings Include:</p> <p>Review of facility policy Lab and Diagnostic Test Results - Clinical Protocol revised November 2018 reveled the physician will identify, and order lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests.</p> <p>Review of Resident R118's clinical record revealed a physician order dated January 23, 2024, ordered by Nurse Practitioner, Employee E19, for laboratory values to be drawn on January 24, 2024.</p> <p>Continued review of Resident R118's clinical record revealed an assessment dated [DATE], by Nurse Practitioner, Employee E19, which revealed the Nurse Practitioner was unsure if the labs ordered for January 24, 2024, had been drawn.</p> <p>Review of Resident R118's entire clinical record revealed no documented labs were completed on January 24, 2024, as ordered.</p> <p>Interview on May 24, 2024, at 11:09 a.m. with the Assistant Director of Nursing, Employee E3, confirmed labs ordered for January 24, 2024, for Resident R118 were not completed as ordered.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p> <p>28 Pa. Code 211.12 (d)(3) Nursing Services</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services</p>		

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43277</p> <p>Based on review of clinical records, observations, and staff interview, it was determined that the facility failed to ensure beverages were provided in accordance with resident needs for three of three residents with orders for thickened liquids observed (Resident R1, R140, and R34).</p> <p>Findings Include:</p> <p>Review of Resident R1's Quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated April 25, 2024, revealed the resident was cognitively impaired and had a diagnosis of dysphagia (difficulty swallowing).</p> <p>Review of Resident R1's clinical record revealed a physician diet order dated January 25, 2024, that indicated Resident R1 was ordered nectar thick fluids (liquids that have been altered to a thicker consistency than water - nectar thick liquids are similar to that of fruit nectar).</p> <p>Review of Resident R1's care plan revised May 22, 2024, revealed the resident had a nutritional problem or potential nutritional problem related, but not limited to, mechanically altered diet and dysphagia. Intervention revised January 25, 2024, included to provide nectar thick fluids.</p> <p>Review of Resident R1's clinical record revealed a nutritional progress note dated May 22, 2024, by Registered Dietitian, Employee E9, to continue to encourage intake of meals/fluids with a goal to maintain adequate intake of meals/fluids.</p> <p>Review of Resident R140's quarterly MDS dated [DATE], revealed the resident had moderate cognitive impairment, and a diagnosis of dysphagia.</p> <p>Review of Resident R140's clinical record revealed a physician diet order dated January 19, 2024, that indicated Resident R140 was ordered nectar thick fluids.</p> <p>Review of Resident R140's care plan revised May 22, 2024, revealed the resident had a nutritional problem or potential nutritional problem related, but not limited to, dysphagia and thickened liquids. Intervention revised January 19, 2024, included to provide 120 milliliters (mL) of nectar thick liquids every shift for hydration.</p> <p>Review of Resident R140's nutritional note dated May 16, 2024, by Registered Dietitian, Employee E22, revealed laboratory values were reviewed for Resident R140 which indicated potential dehydration. Interventions included to encourage fluids.</p> <p>Review of Resident R34's comprehensive MDS dated [DATE], revealed the resident was cognitively impaired and had a diagnosis of dysphagia.</p> <p>Review of Resident R34's clinical record revealed a physician diet order dated April 29, 2024, that indicated Resident R34 was ordered nectar thick fluids.</p> <p>(continued on next page)</p>

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident E34's care plan revised April 25, 2024, revealed the resident had a nutritional problem or potential nutritional problem related, but not limited to, dysphagia and altered liquid consistencies.</p> <p>Review of Resident R34's nutritional progress note dated May 23, 2024, by Registered Dietitian, Employee E22, revealed recommendations to encourage fluids.</p> <p>Observations on May 22, 2024, during the lunch time meal service at approximately 12:25 p.m. revealed Residents R1, R140, and R34 were not provided with thickened beverages on their lunch meal trays.</p> <p>Interview and observations on May 22, 2024, at 12:30 p.m. with licensed nurse, Employee E20, confirmed Resident R1, R140, and R34 did not have beverages sent with their lunch time meal.</p> <p>Further observations on May 22, 2024, at 12:30 p.m. with licensed nurse, Employee E20, revealed Resident R1 had a cup of thin water within reach on the overbed table. Licensed nurse, Employee E20, confirmed Resident R1 is supposed to have thickened beverages and was unsure who provided Resident R1 with the incorrect beverage consistency.</p> <p>Interview on May 24, 2024, at 12:37 p.m. with 2nd floor unit clerk, Employee E23, confirmed the kitchen typically sends up individual beverages on each resident meal tray, such as juice, with breakfast, lunch, and dinner.</p> <p>28 Pa. Code 211.10 (d) Resident care policies</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>38947</p> <p>Based on observations, staff interviews and the review of clinical records, it was determined that the facility failed to maintain complete and accurate clinical records for 1 out of 30 residents (Resident R89).</p> <p>Findings include:</p> <p>Review of the facility policy, Charting and Documentation, with a revision date of July 2017, indicated that all services provided to the resident, progress toward the care plan, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The policy also indicated that the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Continued review of the policy indicated that information documented in the medical record should include, but not limited to: Objective observations; treatments or services performed; changes in the resident's condition, and events, incidents or accidents involving the resident.</p> <p>Review of the Resident R89's May 2024 physician orders included the diagnoses of schizophrenia (a mental disorder characterized by false beliefs that conflict with reality, in addition to seeing, hearing, feeling or smelling something that does not exist, disorganized thoughts, speech and behavior); bipolar (a chronic mood disorder that causes intense shifts in mood, energy levels and behavior); diabetes (a group of diseases that affect how the body uses blood sugar); seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness), and glaucoma (a condition that damages the eye's optic nerve, and gets worse over time, unless treated).</p> <p>Review of the psychiatrist consultation notes dated July 11, 2024 for the above referenced visit documented that the resident reported depression to the psychiatrist (a doctor who specializes in physical medicine and rehabilitation), and expressed a passive death wish to him during her visit: Patient seen and examined. Patient reports depression. She asks if I am sending her to [Name of a facility]. She expresses passive death wish; she denies suicidal ideation or desire to harm others.</p> <p>Depression: discussed patient's passive death wish with DOT (Director of Therapy) who will make sure patient is set up with psych services.</p> <p>Review of the resident's nursing notes dated July 11, 2023 at 7:00 p.m. revealed that Employee E12 (licensed nurse) documented that she was asked to see Resident R89 regarding a conversation that the resident had with the psychiatrist. Employee E12 documented that the resident did not have any thoughts of harming herself or others:</p> <p>Asked to see resident regarding her conversation earlier with psychiatrist. Resident did not state that she had any thoughts of harming herself or others. She spoke pleasantly with charge nurse and me. Will continue to monitor resident and psych services are consulted per Social Work.</p> <p>(continued on next page)</p>		

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  05/28/2024
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of the clinical record did not indicate the context of the conversation/exact comment(s) that the resident expressed to physiatrist regarding the passive death wish, that the the physiatrist documented, to ensure that the facility was aware of the specific comments made by the resident regarding a passive death wish so that the facility can make an assessment as to whether or not the comment made by the resident was a passive death wish. Continued review of the clinical record also did not indicate the context of the conversation/exact comment(s) that the resident made to ensure that complete and accurate information regarding her conversation with the physiatrist was documented in her clinical record in its entirety.</p> <p>During an interview with Licensed nurse, Employee E12 on May 28, 2024 at 10:52 a.m. she reported that she was notified by the Director of Nursing (DON) to speak with Resident R89 regarding the physiatrist reporting to the Director of Rehabilitaiton (Employee E27) that the resident had a passive death wish. Employee E12 reported that she did not know what the specifics were regarding the comment that the physiatrist reported, other than just being notified that the resident expressed a passive death wish and that she (Employee E12) needed to speak with the resident.</p> <p>During an interview with the DON on May 28, 2024 at 2:15 p.m. the DON could not provide any information as to what the specific comments were related to the passive death wish that was recorded in the consult and reported to the facility by the physiatrist.</p> <p>28 Pa. Code 211.5 (f)(ii) Medical records</p> <p>28 Pa. Code 211.12(c) Nursing services</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		