

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Hickory House Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3120 Horseshoe Pike Honey Brook, PA 19344	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30934</p> <p>Based on facility policy and procedure review, clinical record review, and staff interviews, it was determined the facility failed to thoroughly investigate incidents for three of 32 residents reviewed. (Residents 2, 95, and 155)</p> <p>Findings include:</p> <p>Review of facility policy and procedure titled Protection of Residents: Reducing the Threat of Abuse & Neglect, reviewed May 15, 2020, revealed when an incident of or suspected incident of resident abuse and/or neglect of unknown source, exploitation or misappropriation of resident property is reported the administrator/designee will investigate the occurrence. The administrator/designee will complete an Incident Report and will utilize the Incident Investigation Questionnaire Form to document the investigation. The written summary of the investigation should include, but is not limited to: a review of the incident report, an interview with the person reporting the incident, interviews of any witnesses to the incident, an interview with the resident if appropriate, a review of the residents medical record, an interview with employees as needed, a review of the employees file as needed, Interviews with staff members on all shifts having contact with the resident at the time of the incident. Interview with the resident's roommate, family, and or visitors which may have information regarding the incident, interview other resident who received care and services from the alleged perpetrator, a review of all circumstances surrounding the incident.</p> <p>Review of Resident 2's clinical record revealed the following diagnosis: Unspecified Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), Cognitive communication deficit (difficulty with communication that is caused by a problem with thinking), Anxiety disorder (intense, excessive and persistent worry and fear about everyday situations.), Major Depressive disorder (a persistent feeling of sadness and loss of interest).</p> <p>Additional review of Resident 2's clinical record revealed Resident 2 was actively prescribed Eliquis (blood thinner, blocks the activity of certain clotting substances in the blood).</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 2's progress notes revealed a progress note dated April 23, 2024, which states the following On this night the CAN (Certified nursing assistant) informed me that this resident had blood on his hand, wrist and on many tissues in the trash can. When assessing the situation, there was a band aide soaked with blood on his left wrist. When the band aide was removed the area was still bleeding. There was approximately a straight line cut approximately 1 centimeter long with no depth nor width on his left wrist. The area kept bleeding. The edges were approximated with 2 steri strips (strong adhesive bandages. They're often used to hold together the edges of a cut or wound, providing support for healing) after cleansing with NSS (normal saline solution). A pressure dressing of 4x4's was applied and wrapped with cling.</p> <p>Interview conducted with Resident 2 on May 29, 2024, at 1:18 p.m. reported that he/she does not remember how he/she sustained a laceration but remembers a male nurse placing a band aid on his wrist.</p> <p>Review of incident report, provided by the Director of Nursing (DON) on May 30, 2024, failed to contain any documentation identifying the nurse that treated Resident 2's wound and failed to provide any evidence of the nurse notifying the supervisor.</p> <p>Additional review of the incident report revealed the DON failed to attain any witness statements.</p> <p>Interview conducted with the Nursing Home Administrator on May 31, 2024, at 11:47 a.m. confirmed the incident was not thoroughly investigated.</p> <p>Review of Resident 95's diagnosis list includes Dementia (term used to describe a group of symptoms affecting memory, thinking, and social abilities severely enough to interfere with daily life), and Metabolic Encephalopathy (A group of neurological disorders that affects the brain due to a chemical imbalance in the blood).</p> <p>Review of Resident 95's Admission Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) revealed resident had a severe cognitive impairment.</p> <p>Review of Resident 95's nursing progress notes dated April 26, 2024, at 7:57 p.m., revealed that at around 9:30 p.m., the nursing supervisor received a call from a state trooper stating that the resident had called 911 due to feeling of not being safe in the facility. The resident informed the nursing supervisor that he/she did not feel safe and would like his/her sleeping pill. The state trooper came to the facility and spoke to the resident who reported that he/she was beaten and tossed into bed by two men. Documentation revealed that as per the trooper, the resident's description of the men who tossed him/her in bed was that of an EMT staff.</p> <p>Review of the facility documentation, Incident Report revealed that on April 26, 2024, at 7:30 p.m., the RN supervisor received a call from the state trooper stating that the resident had called 911 due to not feeling safe in the facility. The report revealed that as per the resident description, he/she was beaten and tossed in bed by two men. The resident was assessed, and the physician and POA were notified.</p> <p>Review of Resident 95's clinical records and facility documentation failed to reveal that a statement was taken from staff that had or possibly was in contact with the resident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Director of Nursing conducted on May 31, 2024, confirmed that there was no documented evidence that staff who had or possibly had contact with the resident was interviewed.</p> <p>The facility failed to ensure Resident 95's allegation of physical abuse was comprehensively investigated.</p> <p>Review of Resident 155's census tab of the clinical record revealed the resident was admitted to the facility on [DATE] from the hospital after a surgical repair of a fractured hip.</p> <p>Review of Resident 155's Progress Notes revealed a Nursing Entry dated April 23, 2024 at 12:03 a.m. stating, This RN (Registered Nurse) was alerted by CNA (Certified Nursing Assistant) that while providing incont (incontinent) care she saw a gold point sticking out of resident's anus; while attempting to wipe resident's buttocks a fully intact writing pen came out of resident's rectum. Resident Alert with confusion and unable to explain how the pen became lodged in his rectum and denied pain. Resident was assessed for trauma none noted.</p> <p>Facility was asked to provide all documentation related to the investigation of this incident upon admission for Resident 155. An incident report was provided but there was no documented evidence any staff, or residents had been interviewed or that the company that had transported the resident to the facility from the hospital, or the hospital itself was contacted by the facility for investigation into this incident.</p> <p>Interview with the Nursing Home Administrator and the Director of Nursing on May 31, 2024 at 11:30 a.m. confirmed there was not a thorough investigation into the incident to Resident 155 upon admission on April 22, 2023.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management</p> <p>28 Pa. Code 201.29(a)(d) Resident Rights</p> <p>28 Pa. Code 211.5(f) Clinical Records</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>41765</p> <p>Based on clinical records review and staff interview, it was determined that the facility failed to follow the physician's orders and notify the physician of missed medications for three of the 24 residents reviewed (Residents 9, 51, and 95).</p> <p>Findings include:</p> <p>Review of Resident 9's physician order dated May 18, 2024, revealed an order for Vancomycin HCL (antibiotic) Oral Capsule 125 mg given one capsule by mouth every 12 hours for C-diff (An inflammation of the colon caused by the bacteria Clostridium difficile) until May 18, 2024.</p> <p>Review of Resident 9's clinical record including May 2024 Medication Administration Record revealed Vancomycin was not administered to the resident until the morning of May 18, 2024, missing three doses due to unavailability of the medication.</p> <p>Review of the physician's progress notes dated May 20, 2024, revealed the assessment and plan: Diarrhea (loose stool), history of recent C-diff, and Vancomycin completed.</p> <p>Review of Resident 9's clinical records failed to reveal that the physician was notified that the resident was only administered one out of four doses of Vancomycin ordered on May 16, 2024, due to the unavailability of the medication from the pharmacy.</p> <p>Interview with Director of Nursing conducted on May 31, 2024, confirmed the physician was not notified of the missed Vancomycin doses ordered on May 16, 2024, until May 21, 2024.</p> <p>Review of Resident 51's physician's orders revealed an physician's order dated February 26, 2024, for Coreg Oral Tablet (beta blocker used to treat high blood pressure and heart failure) 25 milligrams (mg) two times a day at 8 a.m. and 4 p.m., hold for systolic blood pressure (SBP) less than 100 or heart rate (HR) less than 60.</p> <p>Review of Resident 51's May 2024 Medication Administration Report (MAR) revealed the resident received Coreg 25 mg on May 8, 2024, with a documented HR of 59, May 12, 2024, with a documented HR of 56, May 18, 2024, with a documented HR of 59, May 22, 2024, with a documented HR of 54, May 23, 2024, with a documented HR of 55, and May 24, 2024, with a documented HR of 53.</p> <p>Review of Resident 51's April 2024 MAR revealed the resident received Coreg 25mg on April 3, 2024, for a documented HR of 57, April 6, 2024, for a documented HR of 57, April 7, 2024, for a documented HR of 58, April 21, 2024, for a documented HR of 57, April 23, 2024, for a documented HR of 56, April 26, 2024, for a documented HR of 55, and April 29, 2024, for a documented HR of 58.</p> <p>Review of Resident 51's March 2024 MAR revealed the resident received Coreg 25mg on March 22, 2024, for a documented HR of 54, and March 23, 2024, for a documented HR of 55.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 51's clinical records revealed a physician note dated April 30, 2024, documenting medication was administered to resident with a documented heart rate of less than 60 for three days in April.</p> <p>Interview conducted on June 3, 2024, at 10:46 a.m. with the Nursing Home Administrator occurred and during which the above information was conveyed.</p> <p>Review of the Resident 95's nursing progress notes dated May 22, 2024, at 2:12 p.m., revealed Nurse Practitioner was in to see the resident due to having loose stools. A new order to continue the current Vancomycin until May 28, 2024, was made.</p> <p>Review of Resident 95's physician's order dated April 24, 2024, revealed an order for Midodrine (medication used to treat low blood pressure) 5 mg give one tablet by mouth three times a day for Hypotension (low blood pressure). Hold for Systolic Blood Pressure (SBP) over 130</p> <p>Review of the May 2024, Medication Administration Record (MAR) revealed that from May 1, 2024, until May 22, 2024, Resident 95 was administered Midodrine 13 times with a systolic blood pressure above 130 ranging from 132/55 mmHg to 169/51 mmHg.</p> <p>Interview with the Director of Nursing on May 31, 2024, confirmed the Midodrine medication was administered to Resident 95 outside of ordered parameters.</p> <p>The facility failed to ensure physician's order for the Midodrine medication administration parameter order was followed.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>41765</p> <p>Based on clinical records review, facility documentation review, and staff interviews, it was determined that the facility failed to provide appropriate assessment and supervision to prevent a fall for one of the 24 residents reviewed (Resident 35).</p> <p>Findings include:</p> <p>Review of resident 35's diagnosis list includes Dementia (term used to describe a group of symptoms affecting memory, thinking, and social abilities severely enough to interfere with daily life), and Cerebral Vascular Accident (CVA- interruption in the flow of blood to cells in the brain).</p> <p>Review of Resident 35's Admission Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) dated November 22, 2023, revealed Resident 35 had a severe cognitive impairment and was dependent on transfers. The same MDS revealed car transfer assessment was not attempted due to medical conditions or safety concerns.</p> <p>Review of the active care plan initiated on November 22, 2023, revealed a care plan for ADLs (activities of daily living) which indicated that Resident 35 was an extensive assistance with two (persons) with transfers using the hemi walker (A kind of walker used for patient with full or partial paralysis on one side of the body).</p> <p>Review of the facility documentation and incident Report revealed that on January 1, 2024, at 11:45 a.m., the resident was found on the floor in the driveway outside of the facility by the main entrance on the passenger side of the family van. The family (grandson) signed the resident out for an outing. As per the resident, her/his knees got weak, and was unable to stand to get into the van causing the fall.</p> <p>Interview conducted with the Director of Nursing on May 31, 2024, revealed that for a resident going out on pass and requiring a two-person assist with transfers, rehab will be notified to assess the resident's safety with car transfers.</p> <p>Interview conducted with licensed Physical Therapist Employee E3 conducted on May 31, 2024, revealed that the rehab department was not notified that Resident 35 was going out on pass with a family. Employee E3 reported that a car transfer assessment would have been done if they had been informed.</p> <p>Review of the facility documentation revealed that on January 1, 2024, at 10:22 p.m., Resident 35 was assisted by an aide from a wheelchair to the bed but slipped from the chair, the aide lowered the resident to the floor and called for help.</p> <p>Review of the unlicensed employee E5 statement dated January 1, 2024, revealed: I attempted to pivot transfer patient from a chair to bed. The same statement revealed resident was lowered to the floor when she/he slipped.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview conducted with the Director of Nursing on May 31, 2024, confirmed Resident 35 was provided with one person to assist with transfers on the night of January 1, 2024, despite needing a two-person assist with the use of hemi-walker as documented on the resident's plan of care.</p> <p>The facility failed to ensure Resident 35 was provided with appropriate assessment and supervision to prevent two falls in a day.</p> <p>28 Pa. Code 211.10 (c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>41765</p> <p>Based on a review of the facility's policy, observation, clinical records review, and resident and staff interview, it was determined that the facility failed to ensure a physician order for Oxygen use was in place for one of the residents reviewed (Resident 205).</p> <p>Findings include:</p> <p>Review of the facility's policy titled Oxygen Administration, revised on February 27, 2024, revealed that an oxygen order should be written for specific liter flow required by the resident.</p> <p>Review of Resident 205's diagnosis list includes Chronic Obstructive Pulmonary Disease (COPD-A type of lung disease characterized by long-term respiratory symptoms and airflow limitations), Bronchiectasis with an acute lower respiratory infection, and Pleural Effusion (A buildup of fluid between the tissues that line the lungs and the chest).</p> <p>Observation conducted May 28, 2024, at 9:49 a.m., revealed Resident 205 sited in a wheelchair receiving supplemental oxygen per nasal cannula (A device that delivers extra oxygen through a tube and into your nose). An observation of the oxygen concentrator machine gauge revealed resident was receiving supplemental oxygen at two liters per minute (LPM).</p> <p>Interview conducted with Resident 205 on May 28, 2024, at 10:00 a.m., revealed that she/he was on as-needed supplemental oxygen at home but had been using continuous supplemental oxygen since being admitted to the facility four days ago.</p> <p>Observation conducted on May 30, 2024, at 11:35 a.m., revealed Resident 205 in the rehab room receiving supplemental oxygen per nasal cannula at two LPM while doing therapy. An interview with Resident 205 revealed she/he needed supplemental oxygen because she/he got short of breath during exertion.</p> <p>Review of Resident 205's clinical records failed to reveal an active physician's order for supplemental oxygen use and the liter per minute required.</p> <p>Interview with the Director of Nursing conducted on May 31, 2024, at 11:00 a.m., confirmed that there was no physician's order for Resident 205's supplemental oxygen from admission. The DON confirmed that the order was made on May 31, 2024.</p> <p>Review of the physician's order dated May 31, 2024, revealed an order for oxygen at two to four LPM per nasal cannula, which may be titrated to keep saturation above 90%. Notify the physician if saturation needs cannot be met at four liters.</p> <p>The facility failed to ensure that there was a physician's order for the supplemental oxygen use for Resident 205.</p> <p>28 Pa. Code 211.10 (c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>30934</p> <p>Based on facility policy and procedure review, clinical record review and staff interview it was determined the facility failed to ensure residents did not receive unnecessary medications for one of six residents reviewed. (Resident 79)</p> <p>Findings Include:</p> <p>Review of facility policy and procedure titled Definition of Infections for Surveillance Activities, last reviewed May 16, 2024 revealed Identification of infection should not be based on a single piece of evidence but should always consider the clinical presentation and any microbiologic (lab studies) or radiologic (X-rays, CT scan etc.) information that is available. Microbiologic and radiologic findings should not be the sole criteria for defining an event as an infection. Similarly, diagnosis by a physician alone is not sufficient for a surveillance definition of infection and must be accompanied by documentation of complete signs and symptoms.</p> <p>Review of Resident 79's progress notes revealed a nursing entry dated May 10, 2024 at 2:17 p.m. stating CNA (Certified Nursing Assistant) to desk stating resident complaining of dysuria (pain during urination) and was noted to have drops of blood on his penis and in brief. Doctor's office called, await call back.</p> <p>Review of the entire clinical record revealed there was no documented evidence of an assessment of the resident completed by a nurse on Resident 79 related to his complaint of dysuria and the blood noted by the CNA.</p> <p>Further review of Resident 79's progress notes revealed a nursing entry dated May 10, 2024 at 2:30 p.m. stating Doctor's office returned phone call and was updated on resident. He said because it is Friday afternoon and resident is symptomatic with noted blood, he ordered antibiotic.</p> <p>Review of the entire clinical record revealed there was no evidence Resident 79's urine was tested to confirm a urinary infection.</p> <p>Review of Resident 79's Medication Administration Record (MAR) revealed the resident received Amoxicillin-Pot Clavulanate (antibiotic) Tablet 500-125 MG (milligrams) twice a day for five days from May 11-15 2024 for a diagnosis of probable UTI (Urinary Tract Infection).</p> <p>Interview with the Director of Nursing and the Nursing Home Administrator on May 31, 2024 at 11:30 a.m. confirmed Resident 79 did not have a nursing assessment to confirm the signs and symptoms reported to the RN by the CNA or a laboratory study to confirm a UTI and the sensitivity of the organism causing the infection prior to the administration of antibiotics.</p> <p>28 Pa Code 211.5 (f) Clinical records</p> <p>28 Pa code 211.10 (c) Resident care policies</p> <p>28 Pa. 211.12(c)(d)(1)(3)(5) Nursing services</p>		