STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395460	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christ the King Manor	1100 West Long Avenue Dubois, PA 15801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 19102 Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for seven of 42 residents reviewed (Residents 17, 52, 63, 64, 98, 103, 117). Findings include: The Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, revealed that Section O0110G1b (non-invasive mechanical ventilator) and Section O0110G3b (CPAP- Continuous positive airway pressure - a machine that uses mild air pressure to keep breathing airways open while sleeping) was to be checked if a CPAP device was used while a resident at the facility during the seven-day assessment period. Physician's orders for Resident 17, dated March 25, 2024, included an order for the resident to use a CPAP with humidification at bedtime with oxygen at 2 Liters per minute (L/min) every night. A quarterly MDS for Resident 17, dated April 20, 2024, revealed that Section O0110G1b and Section O0110G3b were not checked indicating that the resident did not use a CPAP device during the seven-day assessment period. Review of the MAR for Resident 17 dated April 2024 revealed that the resident used a CPAP device every night during the seven-day assessment period. Interview with the Director of Nursing on June 13, 2024, at 7:46 a.m. confirmed that Section O0110G1b and Section O0110G3b of Resident 17's quarterly MDS assessment, dated April 20, 2024, should have been checked to indicate that he used a CPAP device during the seven-day assessment period but was not. The Long-Term Care Facility RAI User's Manual, dated October 2023, revealed that Section N0415C should be checked if the resident received an antidepressant medication, Section N0415G was to be checked if the resident received a diuretic medication, and Section N0415H was to be checked if the resident received an opioid (pain medication) medication during the seven-day assessment period. (continued on next page)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for Resident 52, dated May 15, 2024, included an order for the resident to receive 2 milligrams (mg) of Bumetanide (diuretic) one time a day and 10 mg of Fluoxetine (an antidepressant) one time day. Physician's orders, dated April 5, 2024, included an order for the resident to receive 50 mg of Tramadol (opioid pain medication) once daily at bedtime. A quarterly MDS for Resident 52, dated May 21, 2024, revealed that Section N0415C, Section N0415G, and Section N0415H where not checked, indicating that the resident did not receive a diuretic medication, an antidepressant medication, or an opioid medication during the seven-day look-back assessment period. Review of the MAR for Resident 52, dated May 2024 revealed that the resident received 2 mg of Bumetanide once a day, 10 mg of Fluoxetine once a day, and 50 mg of Tramadol once a day during the seven-day assessment period. Interview with the Director of Nursing on June 13, 2024, at 7:45 a.m. confirmed that Section N0415C, Section N0415G, and Section N0415H of Resident 52's quarterly MDS assessment for May 15, 2024, was checked incorrectly and should have been checked to indicate that she received a diuretic, antidepressant, and opioid medication during the seven-day assessment period. The Long-Term Care Facility RAI User's Manual, dated October 2023, revealed that Section O0110J1b was to be checked if the resident was receiving dialysis treatment while a resident at the facility during the seven-day assessment period. Physician's orders for Resident 63, dated August 2, 2023, included an order to ensure communication forms are sent with the resident to dialysis every Monday, Wednesday, and Friday, and to ensure the form is received back upon return. A quarterly MDS for Resident 63, dated June 5, 2024, revealed that section O0110J1b was not checked, indicating that the resident did not receive dialysis treatment during the seven-day assessment period. Interview with the Director of Nursing on June 13, 2024, at 9:46 a.m. confirmed that section O0110J1b of Resident 63's quarterly MDS assessment, dated June 5, 3024, was not checked to indicate that she was receiving dialysis treatments while a resident at the facility during the seven-day assessment period and it should have been. The RAI User's Manual, dated October 2023, revealed that if a resident used oxygen, then Section O0110C was to be checked if it applied. Physician's orders for Resident 64, dated February 23, 2024, and March 21, 2024, included orders for the resident to use a CPAP with oxygen at 2 liters per minute (lpm) during the evening and night shift and to receive 2 liters of oxygen per minute every shift. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 64's MAR for March 2024 revealed that the resident used a CPAP device during the evening and night shift and received 2 liters of oxygen every shift from March 1 to 31, 2024. However, a quarterly MDS assessment, dated May 29, 2024, revealed that Section O0110G1b and Section O0110G3b were not checked, indicating that the resident did not use a CPAP device during the review period, and Section O0110C was not checked, indicating that the resident did not receive oxygen during the review period. Interview with the Director of nursing on June 13, 2024, at 7:45 a.m. confirmed that Resident 64's quarterly MDS of May 29, 2024, was coded incorrectly. The RAI User's Manual, dated October 2023, revealed that if the resident had a fall since admission, entry or re-entry, or a prior assessment, then Section J1800 was to be coded (1) Yes, and Section J1900 was to be completed. If the resident had a fall with no injury since admission, entry or re-entry, or a prior assessment then J1900A was to be coded with the number of falls. If the resident had a fall with an injury (skin tears, abrasions, lacerations, superficial bruises, hematoma) since admission, entry or re-entry, or a prior assessment then Section J1900B was to be coded with the number of falls. If the resident had a fall with a major injury (bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma) since admission, entry or re-entry, or a prior assessment then Section J1900C was to be coded with the number of falls. An investigation report and nursing note for Resident 98, dated March 27, 2024, at 10:53 p.m. revealed that the resident was found lying on the floor in the resident's room. He was having some pain with his knee and was reluctant to bend it. An x-ray result, dated March 28, 2024, revealed that the resident had an acute fracture of the right hip. A significant change MDS assessment for Resident 98, dated April 6, 2024, revealed that Section J1800 was incorrectly coded zero (0) - No, indicating that the resident had no falls since admission, entry or re-entry, or the prior assessment. By coding Section J1800 as (0) No, the computerized MDS software did not allow Sections J1900C to be completed to reflect that the resident had a fall and fracture. Interview with the Director of nursing on June 13, 2024, at 7:45 a.m. confirmed that Resident 98's significant change MDS assessment of April 6, 2024, was coded incorrectly. An investigation report and nursing note for Resident 103, dated May 14, 2024, at 6:57 a.m. revealed that the resident was found lying on the floor beside his bed and had a 3.0 centimeter (cm) superficial scratch to his forehead. A significant change MDS assessment for Resident 103, dated May 18, 2024, revealed that Section J1900 was coded (1) indicating that the resident had one fall with a major injury. Interview with the Director of nursing on June 12, 2024, at 1:25 p.m. confirmed that Resident 103's admission MDS assessment of May 18, 2024, was coded incorrectly. A discharge MDS for Resident 117, dated April 28, 2024, revealed that section A2105 indicated the resident was discharged to a short-term general hospital. Physician's orders for Resident 117, dated April 28, 2024, included an order to discharge to home. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing on June 13, 2024, at 9:46 a.m. confirmed that Section A2105, Resident 117's discharge MDS assessment, dated April 28, 2024, should have been checked to indicate that the resident was discharged to home. 28 Pa. Code 211.5(f) Clinical Records.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 31760 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that an enteral feeding was administered in accordance with physician's orders for one of 42 residents reviewed (Resident 67). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 67, dated April 25, 2024, revealed that the resident was understood, could understand others, and had a feeding tube. A care plan for the resident, dated February 9, 2024, revealed that the resident required supplemental tube feed (a way to provide nutrition when you cannot eat or drink safely by mouth) and fluids via percutaneous endoscopic gastrostomy (PEG -the placement of a feeding tube through the skin and the stomach wall) tube to meet nutritional/hydration needs. Staff were to give 240 milliliters (ml) of Glucerna (a tube feeding formula) daily for inadequate oral intake via PEG-tube as ordered. A care plan, dated May 6, 2024, revealed that the resident has a potential nutritional problem related to impaired oral intake and the need for a mechanically altered diet. Staff was to provide and serve supplements as ordered: Give 240 ml of Glucerna 1.5 Cal via PEG-tube after meals for impaired oral intake when she consumes less than three points of her meal (a system used to explain the amount eaten). Physician's orders for Resident 67, dated November 8, 2023, included an order for staff to give 240 ml of Glucerna 1.5 Cal via PEG-tube after meals for impaired oral intake when she consumes less than three points of her meal. Resident 67's amount eaten record for April and May 2024 indicated that the resident ate four points during the lunch meal and five points during the supper meal on April 15, 2024; ate three points during the lunch meal on April 29, 2024; ate six points during the lunch meal on May 7, 2024; ate four points during the supper meal on May 15, 2024; ate three points during the lunch meal on May 19, 2024; ate three points during the lunch meal on May 23, 2024; and ate four points during the supper meal on May 27, 2024. However, Resident 67's Medication Administration Records, dated April and May 2024, indicated that she received the 240 ml bolus feeding of Glucerna 1.5 Cal on the above dates. Interview with the Director of Nursing on June 13, 2024, at 9:56 a.m. confirmed that Resident 67 received the 240 ml bolus feeding of Glucerna 1.5 Cal on the above dates when her meal points were three and/or above and that she should not have been given the 240 ml bolus feeding of Glucerna 1.5 Cal. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 31760 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that clinical records were complete and accurately documented for two of 42 residents reviewed (Residents 24, 67). Findings include: A significant change in status Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated April 20, 2024, revealed that the resident was usually understood, could usually understand others, and had a diagnosis of dementia. Physician's orders for Resident 24, dated April 16, 2024, included an order for staff to cleanse the resident's left buttocks with wound cleanser then apply Chamosyn ointment (used to protect skin from wetness, urine, or stools) to her Peri wound (the area around the wound) and place Xeroform (a fine mesh gauze occlusive dressing impregnated with petrolatum and 3 percent Xeroform) to her open wounds. Then place an ABD pad (a gauze dressing that absorbs fluid from large or heavily draining wounds) every day and evening shift and as needed with each incontinence. Physician's orders for Resident 24, dated April 15, 2024, included an order for the resident to receive 0.25 milliliters (ml) of morphine sulfate (used to treat moderate to severe pain) every three hours as needed for pain/shortness of breath. Physician's orders for Resident 24, dated June 7, 2024, included an order for staff to administer the as needed Roxanol (the brand name for morphine) 15-20 minutes prior her to wound care every shift. Resident 24's Treatment Administration Record (TAR), dated June 2024, indicated that the night shift staff documented as administering the as needed Roxanol 15-20 minutes prior her to wound care June 7 through 11, 2024. However, there was no documented evidence in the resident's clinical record and/or TAR that the night shift completed any wound care. Interview with the Director of Nursing on June 12, 2024, at 12:15 p.m. confirmed that there was no documented evidence that the night shift completed any wound care on Resident 24 and that they should not be documenting the administration of the Roxanol 15-20 minutes prior to her wound care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS assessment for Resident 67, dated April 25, 2024, revealed that the resident was understood, could understand others, and had a feeding tube. A care plan for the resident, dated February 9, 2024, revealed that the resident requires supplemental tube feed (a way to provide nutrition when you cannot eat or drink safely by mouth) and fluids via percutaneous endoscopic gastrostomy (PEG -the placement of a feeding tube through the skin and the stomach wall) tube to meet nutritional/hydration needs. Staff were to give 240 milliliters (ml) of Glucerna (a tube feeding formula) daily for inadequate oral intake via PEG-tube as ordered. A care plan, dated May 6, 2024, revealed that the resident has a potential nutritional problem related to impaired oral intake and the need for a mechanically altered diet. Staff was to provide and serve supplements as ordered: Give 240 ml of Glucerna 1.5 Cal via PEG-tube after meals for impaired oral intake when she consumes less than three points of her meal. Physician's orders for Resident 67, dated November 8, 2023, included an order for staff to give 240 ml of Glucerna 1.5 Cal via PEG-tube after meals for impaired oral intake when she consumes less than three points of her meal. Physician's orders for Resident 67, dated November 2, 2023, included an order for staff to flush the resident's PEG-tube with 30 ml of warm water before and after each feeding. Resident 67's Medication Administration Records (MARs), dated May and June 2024, indicated that staff did not give the 240 ml of Glucerna 1.5 Cal via Peg-tube on May 7, 2024, at 8:30 a.m.; on May 12, 2024, at 8:30 a.m. and 12:30 p.m.; on May 17, 2024, at 8:30 a.m.; on May 19, 2024, at 8:30 a.m.; on May 20, 2024, at 8:30 a.m. and 6:30 p.m.; on May 21, 2024, at 8:30 a.m., 12:30 p.m., and 6:30 p.m.; on May 22, 2024, at 8:30 a.m. , 12:30 p.m., and 6:30 p.m.; on May 23, 2024, at 8:30 a.m.; on May 24, 2024, at 8:30 a.m.; on May 25, 2024, at 8:30 a.m. and 6:30 p.m.; on May 26, 2024, at 12:30 p.m.; on May 27, 2024, at 12:30 p.m.; on May 30, 2024, at 6:30 p.m.; on May 31, 2024, at 12:30 p.m.; on June 1, 2024, at 8:30 a.m.; on June 2, 2024, at 8:30 a. m.; on June 3, 2024, at 6:30 p.m.; on June 6, 2024, at 6:30 p.m.; on June 7, 2024, at 8:30 a.m., 12:30 p.m., and 6:30 p.m.; on June 8, 2024, at 6:30 p.m.; on June 9, 2024, at 6:30 p.m.; on June 10, 2024, at 8:30 a.m. and 12:30 p.m.; on June 11, 2024, at 8:30 a.m., and 12:30 p.m.; and on June 12, 2024, at 8:30 a.m. However, Resident 67's TARs, dated May and June 2024, indicated that the staff documented as flushing the resident's PEG-tube with 30 ml of warm water before and after each feeding on the above dates and times. Interview with the Director of Nursing on June 13, 2024, at 7:50 a.m. confirmed that staff documented as flushing the resident's PEG-tube with 30 ml of warm water before and after each feeding on the above dates and times when the resident did not receive the 240 ml of Glucerna 1.5 Cal via Peg-tube. 28 Pa. Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.