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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395466 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/05/2024 |
| NAME OF PROVIDER OR SUPPLIER Milford Healthcare and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 264 Route 6 & 209 Milford, PA 18337 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on review of clinical records, and staff interview, it was determined that the facility failed to timely notify a resident's representative of a significant change in condition and the need to potentially commence a new form of treatment for one resident out of 17 sampled (Resident 1).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses of dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain).</p> <p>Resident 1's quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated October 9, 2023, revealed that the resident was moderately cognitively impaired.</p> <p>A nursing note dated December 28, 2023, at 7:38 PM revealed that the resident was seen by the physician and a dermatology consult was ordered for a cancerous lesion on the left side of the resident's face.</p> <p>There was no documentation found that the facility had contacted the resident's identified representative regarding this change in condition, or that the resident's representative had been made aware of the dermatology consult.</p> <p>A review of a nursing note dated February 14, 2024, at 8:15 PM revealed that the resident left the facility and was seen by dermatology. Nursing noted that the resident had a biopsy completed while at the appointment and had a neoplasm (abnormal tissue growth, a characteristic of cancer) of uncertain behavior to the left nasal area.</p> <p>There was no documented evidence that the resident's representative was made aware the resident was going out for an dermatology appointment or documented evidence that the resident's representative had been informed that the resident had a biopsy completed to rule out cancer of the resident's face.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>An interview with the Director of Nursing on March 5, 2024, at approximately 1:50 PM confirmed the facility failed to notify the resident's representative of the resident's change in condition.</p> <p>28 Pa. Code 211.12 (d)(3) Nursing services</p> <p>28 Pa. Code 201.29 (a) Resident rights</p> |

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| <p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p> | <p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on review of clinical records and written notices of facilit initiated transfers and staff interview it was determined that the facility failed to provide sufficiently detailed written notices of facility initiated transfers to the resident and the residents' representative for three out of three residents reviewed (Residents 1, 2, and 3) by failing to identify the reasons for the move in writing and in a language and manner they understand.</p> <p>Findings include:</p> <p>A review of the clinical record of Resident 1 revealed that the resident was transferred to the hospital on January 30, 2024, and returned to the facility on [DATE].</p> <p>A review of the clinical record of Resident 2 revealed that the resident was transferred to the hospital on February 7, 2024, and returned to the facility on [DATE].</p> <p>A review of the clinical record of Resident 3 revealed that the resident was transferred to the hospital on February 5, 2024, and returned to the facility on [DATE].</p> <p>Further review of these residents' clinical records revealed that the written transfer notices lacked the reason for the transfer. All three written notices indicated that the residents needed a higher level of care.</p> <p>During an interview with the Nursing Home Administrator and Director of Nursing on March 5, 2024, at approximately 1:50 PM, the facility failed to provide documented evidence of the provision of written transfer notices, which identified the reasons for the move in writing and in a language and manner the residents and their representatives understand.</p> <p>28 Pa. Code 201.29 (a) Resident rights</p> |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on review of clinical records and select facility policy, and staff interview it was determined that the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure that licensed nurses accurately administered prescribed medications to one of 17 sampled residents (Resident 4).</p> <p>Findings included:</p> <p>According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understanding and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records.</p> <p>A review of the clinical record of Resident 4 revealed admission to the facility on [DATE], with diagnoses, which included hypertension, congestive heart disease, and orthopedic aftercare, following a left hip fracture.</p> <p>A physician order dated February 6, 2024, was noted for Metoprolol Tartrate 50 mg one tablet orally two times a day for diagnosis of hypertension; hold the medication for systolic blood pressure (top number on blood pressure reading) less than 100 or heart rate less than 60.</p> <p>A review of Resident 4's medication administration record dated February 2024, revealed that on February 6, 2024, at 5 PM nursing staff administered the medication when the resident's heart rate was 59. On February 7, 2024, at 5 PM nursing staff administered the medication with a blood pressure of 98/43. On February 20, 2024, at 5 PM nursing administered the medication with a heart rate of 58.</p> <p>Interview with the Director of Nursing on March 5, 2024, at approximately 1:30 p.m. confirmed that the facility's licensed nurses failed to consistently administer Resident 4's antihypertensive medication as prescribed.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services</p> |