

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 03/26/2024
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<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 transfer notices and staff interview it was determined that the facility failed to provide written notices of facility initiated transfers to the resident and the residents' representative that were written in a language that was easily understood for three out of 11 residents reviewed (Residents CR1, A7, and A8).</p> <p>Findings include:</p> <p>A review of the clinical record of Resident CR1 revealed the resident was transferred to the hospital on March 22, 2024, and did not return to the facility.</p> <p>A review of the resident's Notice of Transfer or Discharge letter revealed the resident was transferred to the hospital due to respiratory distress.</p> <p>A review of the clinical record of Resident A7 revealed the resident was transferred to the hospital on March 25, 2024, and returned to the facility on [DATE].</p> <p>A review of the resident's Notice of Transfer or Discharge letter revealed the resident was transferred to the hospital due to tachycardia and hypotension.</p> <p>A review of the clinical record of Resident A8 revealed the resident was transferred to the hospital on March 26, 2024, and remained in the hospital.</p> <p>A review of the resident's Notice of Transfer or Discharge letter revealed the resident was transferred to the hospital due to respiratory distress.</p> <p>The facility failed to provide notices of facility initiated transfers to the hospital that identified the reason for the residents' transfers in a language that was easily understood.</p> <p>During an interview with the Nursing Home Administrator and Director of Nursing on March 26, 2024, at approximately 3:30 PM, confirmed that the reasons for the residents' transfers were written in medical or diagnosis terms, which may not be easily understood by the residents and their representatives.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>13456</p> <p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on observation, review of clinical records, and resident and staff interviews it was determined the facility failed to provide physician ordered nutritional supplementation as prescribed to promote adequate nutritional status and paramaters of three out of 11 sampled residents sampled (Residents A4, A5, and A6).</p> <p>Findings include:</p> <p>A review of Resident A4 clinical record revealed a physician's order dated February 13, 2024 for Ensure, a nutritional supplement, scheduled for administration to the resident at 2:00 PM daily. It was noted that the supplement will be labeled in the medication room and Boost, another nutritional supplement product, was allowed as a substitution.</p> <p>During an observation of the first floor medication room on March 26, 2024, at 9:15 AM revealed three nutritional supplements, two Boost supplements and one Ensure supplement labeled with Resident A4's name and dated for administration to the resident on March 15, March 16, and March 17, 2024. However, a review of Resident A4's MAR (medication administration record) revealed that staff documented that the resident had received the supplements on March 15, 2024 and March 16, 2024, and refused the supplement on March 17, 2024.</p> <p>A review of Resident A5 clinical record revealed a physician's order dated March 4, 2024 for Glucerna, scheduled for administration at 2:00 PM, as a nutritional supplement for weight loss. It was noted that the supplement will be labeled in the medication room and Boost Glucose Control can be allowed as a substitution.</p> <p>An observation first floor medication room on March 26, 2024, at 9:15 AM revealed three Glucerna nutritional shakes with Resident A5's name and dated for scheduled administration to the resident on March 17, March 21, and March 22, 2024. A review of Resident A5's MAR revealed staff documented that the resident received the supplement on each of these dates, March 17, 21, and March 22, 2024.</p> <p>An interview conducted with Resident A5 at 11:00 AM on March 26, 2024, revealed that the resident stated that the facility does not consistently provide the supplement daily, stating that sometimes staff will give it to her and on other days, they will not.</p> <p>A review of Resident A6 clinical record revealed a physician's order dated February 15, 2024 for Ensure at 2:00 PM with a straw as nutritional supplement.</p> <p>An observation of the second floor medication room on March 26, 2024, at 10:00 AM revealed a Boost nutritional supplement with Resident A6's name with a date of March 21. A review of Resident A6's March 2024 MAR revealed that staff documented that the resident was provided the supplement on March 21, 2024, as ordered.</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 - Some</p>	<p>Interview with Employee 3, the Dietary Manager, on March 26, 2024, revealed that the dietitian writes the residents name on the prescribed nutritional supplement with the date they are to be provided to the resident. She stated that the date on the supplement is the date they should be consumed by the resident. When asked why these supplements remained in the medication rooms, she stated that there were not provided to the residents as ordered on those dates.</p> <p>Interview with the director of nursing (DON) on March 26, 2024 at 3:45 PM confirmed the physician orders for provision of the nutritional supplements were not consistently followed. The DON confirmed that staff had documented that the residents were provided, or had refused the nutritional supplements, which were observed to remain in the medication rooms.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p> <p>28 Pa. Code 211.5 (f) Medical records</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>13456</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, review of select facility policy and staff interview it was determined the facility failed to store and maintain oxygen equipment in a safe, functional and sanitary manner on the second floor nursing unit and in the general storage area.</p> <p>Findings include:</p> <p>A review of the undated facility policy, provided during the survey ending March 26, 2024, entitled Oxygen Storage Policy revealed oxygen tanks are to be stored in an area that is well ventilated, dry and away from sources of heat, open flames or flammable materials. Empty tanks can be stored in a secured medication room and or treatment room until maintenance and or designee is notified to collect and take the designated to the storage location.</p> <p>An observation on March 26, 2024, at 9:30 AM revealed four oxygen cylinders located in the medication/pantry area on the second floor. Two of the cylinders had white plastic caps on the valve posts of the metal oxygen cylinder to indicate the cylinder was not used or full. The other two cylinders had regulators (device attached to oxygen tank post used to deliver the oxygen) attached, which indicated they were used or empty.</p> <p>Interview with Employee 1, an LPN, on March 26, 2024, at the time of the observation, regarding the storage location of full clean and used empty tanks, revealed that the nurse stated that she was only per diem and did not know that answer. When asked where the policy regarding oxygen storage could be located, she stated she was not sure.</p> <p>Interview with Employee 2, RN. at 9:37 AM on March 26, 2024, Employee 2 stated that used oxygen tanks are to be taken outside to the cage where the clean and dirty oxygen cylinders are stored. When asked why used (dirty) and unused (clean) oxygen tanks were stored together in the medication/pantry she stated the used tanks should have been taken off the unit but a few new tanks are stored in a carrier in the medication/pantry for use if needed.</p> <p>A review of the oxygen storage area on March 26, 2024, at 1:00PM, revealed that the storage area was located outside of the building in a caged in area against the building, that was accessed by exiting through the doorway at the end of the facility hallway near the boiler room and the laundry area. The area was located against the wall to the boiler room. Multiple staff were observed outside this door smoking, while on break. The smoking area was also located near the caged area.</p> <p>Multiple oxygen tanks, more than 40 tanks, were stored in this caged in area with signs on the left reading full and the right side empty. However, both empty and full tanks were observed mixed together, revealing some used dirty tanks mixed in with the clean tanks that were sealed.</p> <p>The facility failed to maintain oxygen cylinders in a safe and sanitary manner as evidenced by the storage of unused clean full tanks with the used/dirty empty tanks and ensuring the storage area was away from heat sources such as staff smoking area.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing services</p> <p>(continued on next page)</p>		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.18 (e)(2.1) Management

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456</p> <p>Based on observation and staff interview, it was determined that the facility failed to ensure adherence to use by/expiration dates of pharmaceutical products in the facility's central supply room.</p> <p>Findings include:</p> <p>Observations of the facility's central supply room on [DATE], at approximately 10:00 AM revealed 35 bottles of Hydrogen Peroxide that expired [DATE].</p> <p>There were 10 IV starter kits that expired [DATE].</p> <p>An interview with DON (director of nursing) on [DATE], at the time of the observation confirmed the pharmacy supplies expired and should have been discarded.</p> <p>During an interview with the Nursing Home Administrator on [DATE] at approximately 3:30 PM confirmed expired pharmacy products should have been removed from the storage room and discarded.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456</p> <p>Based on facility policy review, observations, and staff interviews, it was determined the facility failed to store food items under sanitary conditions in the facility's kitchen and two of two resident pantry areas (first and second floors).</p> <p>Findings include:</p> <p>Review of facility policy, titled Food Receiving and Storage, policy and procedure review date of [DATE], included the following but not limited to:</p> <p>Food items and snacks kept on the nursing units must be maintained as indicated below:</p> <ul style="list-style-type: none"> a. All food items to be kept below 41 degrees F must be placed in the refrigerator located at the nurses' station and labeled with a use by date. b. All foods belonging to residents must be labeled with the resident's name, the item and the "use by" date. c. Refrigerators must have working thermometers and be monitored for temperature according to state-specific guidelines. d. Beverages must be dated when opened and discarded after twenty-four (24) hours. e. Other opened containers must be dated and sealed or covered during storage. f. Partially eaten food may not be kept in the refrigerator. <p>Observations of the facility's kitchen on [DATE], at approximately 8:40 AM revealed a prep cooler with the following items that were not labeled and dated as to when they were opened/received/prepared:</p> <ul style="list-style-type: none"> 10 containers of mandarin oranges 2 cupcakes 1 bottle of lemon juice 2 ham and cheese sandwiches 1 turkey and cheese sandwich 1 container of turkey base 1 container of liquid egg whites <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1 package of sandwich thins</p> <p>1 bottle of a protein shake</p> <p>1 container of chopped garlic.</p> <p>An interview with Employee 4 cook/dietary aide on [DATE], at 8:55 AM confirmed the aboved mentioned food was not labeled or dated in the prep cooler and stated that everything should be labeled or dated when first opened, put into use or received.</p> <p>Observation of the first floor nurses' station medication room/pantry on [DATE], at 9:00 AM revealed a refrigerator which contained a bag of salad in a shopping bag, with no name or date, that contained a shopping receipt with purchase date of [DATE]. The pre-cut salad was wet with slimy wilting lettuce leaves.</p> <p>A Ready Shake was located on the door shelf of this refrigerator with no thaw date noted. Interview with Employee 3, the Dietary Manager, at that time indicated that Ready shakes should not be stored in the refrigerator and a thaw date should be noted on the carton as the product should be used within 14 days of thawing or within manufacturer guidelines for use.</p> <p>A package of sliced cheese, wrapped in wax paper, was located in the crisper drawer of the refrigerator with a resident name, Resident A1, noted on the bag but there was no date as to when the cheese was placed in the refrigerator. The wax paper did not cover the entire amount of the cheese slices and the ends of the cheese were visibly dried and hardened to the touch.</p> <p>A half consumed opened 14 oz container of chocolate ice cream was observed in the freezer. Resident A2's name was on the container, but there was no date to indicate when the ice cream was placed in the freezer. The ice cream was crystallized, hardened and appeared discolored.</p> <p>A box of Hot Pockets (microwavable turnover containing meat and cheese) was located on the refrigerator door with Resident A2's name. The box contained one hot pocket and the box indicated keep frozen. This product was not dated and not kept frozen as per manufacturer directions.</p> <p>Interview with Employee 3, the Dietary Manager, on [DATE], confirmed that food items are to be labeled and dated with resident names and any opened items should be dated when opened or in use.</p> <p>Following surveyor observations on the first floor pantry, upon entry to the second floor nurses' station medication room/pantry on [DATE], at 9:30 AM dietary staff were present and attempting to date opened items in the refrigerator with a red marking pen.</p> <p>The refrigerator contained two bottle of 32 ounce Boathouse Farms berry juice both opened and in use, and at that time containing only half the juice in the bottle, dated [DATE], indicated date of opening for use, in red marker. Employee 3 stated this type of juice is not provided by the facility.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A bottle of nectar thick apple juice with approximately three quarters of the juice remaining, had a date of [DATE] in red marking pen, indicating opened for use date on this same date. The manufacturer directions on the thickened juice indicated the juice is to be discarded if not used within ten days of opening. There was no way to determine the actual date of opening since dietary staff dated all the undated items in the pantry as initially opened on [DATE].</p> <p>The shelf on the door of the refrigerator revealed an opened jar of jam containing with half of the jam. The jar was not labeled with a name or date when opened.</p> <p>A container of fresh blueberries with Resident A3's name was located on the shelf with no date to indicate when the container was placed on the shelf.</p> <p>Interview with Employee 3, Dietary Manager, on [DATE], at 11:45 AM, revealed that food and beverage items should be labeled and dated per policy, and discarded once expired, or beyond their use by date, and it was the facility's expectation that expired items are discarded.</p> <p>28 Pa. Code 211.6(f) Dietary services</p>