

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  08/15/2024
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</b></p> <p>Based on review of select facility policy and clinical records, and staff interview, it was determined the facility failed to timely notify the physician and the resident's representative of an incident with the potential to require physician intervention for one resident out of 16 sampled (Resident 115).</p> <p>Findings include:</p> <p>A review of the facility Change in Resident's Condition or Status Policy last reviewed, June 2024, revealed it is the policy of the facility to promptly notify the resident, his or her attending physician, and resident representative of changes in the resident's medical/mental condition and/or status.</p> <p>A review of the clinical record revealed Resident 115 was discharged from the facility to the hospital on July 27, 2024, and readmitted to the facility on [DATE], with diagnoses which included a urinary tract infection, cerebral infarction (stroke), and seizures. A Midline catheter (a long, thin, flexible tube that is inserted into a vein in the upper arm to safely administer medication or fluids into the bloodstream) was present in the resident's arm upon readmission to the facility.</p> <p>A nurses note dated August 12, 2024, at 5:38 PM noted the Midline catheter was assessed after the flush showed leaking around the dressing. The Midline catheter was dislodged. It was removed and measured eight centimeters. Further it was noted the tubing was intact. The area was cleansed and dressed with a dry sterile dressing and Tegaderm (dressing used to protect catheter sites) was applied.</p> <p>A late entry nurses note dated August 14, 2024 (two days after the incident), noted the physician was notified that the Midline catheter was dislodged, removed, and was intact.</p> <p>Further review of the clinical record revealed no documented evidence the resident's resident representative was notified of the dislodgement and discontinuation of the Midline catheter.</p> <p>An interview with the Director of Nursing (DON) on August 14, 2024, at approximately 11:00 AM failed to provide documented evidence the facility timely notified the resident's attending physician of the dislodgement and removal of the resident's Midline catheter. The DON confirmed there was no documented evidence the resident's resident representative was notified of the dislodgement and removal of the Midline catheter.</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 - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa Code 211.12 (c)(d)(3)(5) 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**</b> 21738</p> <p>Based on a review of clinical records, and staff interview, it was determined the facility failed to address a resident's skin condition on the comprehensive care plan for one out of 16 sampled residents (Resident 23).</p> <p>Findings include:</p> <p>A review of the clinical record revealed Resident 23 was admitted to the facility on [DATE], with diagnoses which include congestive heart failure, cerebrovascular accident (CVA- stroke, interruption in the flow of blood to cells in the brain), and rheumatoid arthritis.</p> <p>A physician order dated June 27, 2024, noted an order to apply Zinc to buttocks every shift for skin protectant/moisture barrier.</p> <p>A wound progress note dated August 1, 2024, indicated the resident's sacrum (large, triangle-shaped bone in the lower spine that forms part of the pelvis) was assessed and was noted to have MASD (Moisture-associated skin damage caused by prolonged exposure to various sources of moisture, including urine or stool, or perspiration) of the epidermis resulting from prolonged exposure to various sources of moisture and potential irritants measuring 3 cm (centimeters) x 5 cm x 0.1 cm. The area is open with light serous exudate (clear, thin, watery plasma that is a normal part of wound healing). The treatment plan was to apply Zinc ointment twice daily for 30 days. Further recommendations included, limit sitting to 60 minutes, off-load wound, reposition per facility protocol, turn side to side in bed every one to two hours if able.</p> <p>A wound progress note dated August 8, 2024, indicated that the MASD on the resident's sacrum now measures 3 cm x 4 cm x 0.1 cm. the area is open with light serous exudate and noted to be improved. The dressing treatment plan was to continue to apply Zinc ointment twice daily for 30 days. Further the recommendations were to continue to limit sitting to 60 minutes, off-load wound, reposition per facility protocol, turn side to side in bed every one to two hours if able.</p> <p>A review of Resident 23's comprehensive plan of care (a tool used to organize aspects of patient care) conducted during the survey on August 14, 2024, revealed the resident's care plan did not address the resident's moisture associated skin disorder, treatment, and specific interventions to prevent recurrence.</p> <p>Interview with the Director of Nursing on August 14, 2024, at approximately 10:30 AM confirmed the resident received treatment for the MASD, and the MASD was not addressed on the resident's care plan along with preventative measures to address the resident's identified risk factors to promote optimal healing and prevent recurrence.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39929</p> <p>Based on clinical record review, observation, and staff interviews, it was determined the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for one of 16 residents reviewed (Residents 51).</p> <p>Findings include:</p> <p>According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals.</p> <p>Review of Resident 51's clinical record revealed admission to the facility on [DATE], with diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning).</p> <p>Review of an incident report dated July 2, 2024, indicated the resident had a skin tear on her right shin measuring approximately 7cm centimeters x 6cm.</p> <p>A review of the resident's physicians orders revealed an order for a wanderguard bracelet (a bracelet that triggers alarms and can lock monitored doors to prevent the resident leaving unattended) due to the resident's risk of elopement.</p> <p>Further review of the physician's order revealed no indication of where the bracelet was to be placed on the resident or to check the resident's skin below bracelet routinely.</p> <p>A review of a nursing progress note dated July 14, 2024, revealed the area on resident's right shin had worsened due to swelling and the wanderguard bracelet digging into the skin on the right shin above the ankle.</p> <p>There was no documented evidence the facility staff assessed that the placement of the wanderguard was appropriate after the resident developed skin tear. The facility failed to monitor the resident's skin where the wanderguard was placed resulting in worsening of the resident's wound.</p> <p>An interview with the Nursing Home Administrator, and the Director of Nursing on August 15, 2024, at 11:10 AM, confirmed the facility failed to evaluate and assess the resident's wanderguard placement had to prevent further injury to Resident 51's skin.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</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>41460</p> <p>Based on review of clinical records, select facility reports, observations and staff interview it was determined the facility failed to consistently provide care and services to prevent the development and/or worsening of pressure sores and promote healing for one resident out of 16 residents sampled (Resident 6).</p> <p>Findings include:</p> <p>According to the US Department of Health and Human Services, Agency for Healthcare Research &amp; Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address the areas of risk.</p> <p>The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i. e. support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair.</p> <p>A review of Resident 6's clinical record revealed that the resident was admitted to the facility was on June 10, 2022, with diagnoses that included end stage renal disease with dependence on renal dialysis, diabetes, amputation of bilateral legs above the knees and obesity.</p> <p>A review of Resident 6's care plan initiated August 29, 2023, revealed the resident was at risk for alteration in skin integrity related to impaired mobility, incontinence, and history of scratching, with interventions which included encourage and assist to reposition, encourage resident to remove stump socks at bedtime, provide preventative skin care after each incontinent episode and as needed, pressure reduction device on chair, encourage/assist to suspend/float upper legs to keep stumps off pressure surface, and administer preventative skin treatment per physician orders.</p> <p>Review of a facility investigation dated August 3, 2024, at 8:00 PM, revealed that Resident 6 had a wound that was identified in the left groin. According to the event description, the area was a small hole in patient's groin. Slight bleeding was noted. No pain was indicated. The wound tunneled about a half inch inwards, but diameter was too small to pack. Wound was cleansed with normal saline solution and covered with a dry dressing, Further it was indicated a pending assessment will be completed by treatment team.</p> <p>Review of Change in Condition Evaluation form dated August 3, 2024, at 10:01 PM, indicated that Resident 6 stated she did not scratch the site accidentally and she was unaware it was there. The physician was notified and ordered the resident to be seen by treatment team.</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>The facility failed to provide evidence that Resident 6's tunneling wound acquired on August 3, 2024, was evaluated by the facility's treatment team. There was no evidence that the wound was evaluated for size, drainage, or condition of surrounding tissue.</p> <p>According to additional tracking/monitoring of the wound completed by the DON, the open area on Resident 6's left groin was stable, and as of August 12, 2024, the wound measurements were less than 0.1cm x less than 0.1cm and had no depth or drainage. The form further indicated that the resident would be seen by wound care consultant on August 15, 2024.</p> <p>An interview with the Director of Nursing on August 14, 2024, at approximately 11 AM indicated that the initial description of the wound was based on perception and the initial nurse's evaluation of the wound was inaccurate.</p> <p>On August 14, 2024, at approximately 2:30 PM, the Director of Nursing presented surveyor with a paper Wound Evaluation Flow Sheet which was not found in the resident's clinical records initially dated August 3, 2024, which indicated that the wound measured less than 0.1cm x less than 0.1cm and had no depth, despite the documentation that the wound tunneled approximately a half inch. According to the wound evaluation form completed by the Director of Nursing, the wound did not have drainage, and the surrounding tissue was WNL (within normal limits).</p> <p>Observation of Resident 6's left groin on August 15, 2024, at approximately 8:45 AM, in the presence of Employee 1, registered nurse, revealed an open area which measured approximately 1cm x 1cm with visible depth. Employee 1 did not have depth measuring tool at time of observation. The wound bed was deep red, and surrounding tissue was excessively moist with white substance that appeared fungal in the skin folds. There was no treatment in place at time of observation.</p> <p>Review of wound care consultant evaluation completed on August 15, 2024, revealed that the full thickness(damage extends past the epidermis and dermis, and into the subcutaneous tissue, muscle, bone, or tendons) wound in the left groin measured 0.5cm x 1cm x 0.5cm with a moderate amount of serous (clear) drainage, and 100% granulation (healthy) tissue. Recommendation to discontinue current treatment of dry dressing to wound and apply alginate calcium (highly absorbent and non-occlusive dressing that forms a soft gel when in contact with wound drainage) daily with a gauze island with boarder for 30 days.</p> <p>Interview with the Director of Nursing on August 15, 2024, at approximately 2:10 PM, confirmed that the facility failed to properly assess Resident 6's pressure area and implement interventions to prevent worsening and promote healing in a timely manner.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services.</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</b></p> <p>Based on review of clinical records and select facility policy, staff and resident interviews it was determined the facility failed to ensure that a physician ordered intravenous (IV- medication is administered through needle or tube inserted into a vein) medication, an antibiotic, was timely administered as prescribed for one resident out of 16 sampled (Resident 115).</p> <p>Findings include:</p> <p>Review of the facility policy titled Administering Medications last reviewed by the facility on June 24, 2024, indicated that medications are administered in a safe and timely manner and as prescribed. It indicated that medications are administered in accordance with prescriber orders, including any required time frame. Medication errors are documented, reported, and reviewed by the QAPI (Quality Assurance and Performance Improvement) committee to inform process changes and/or the need for additional staffing. Prescribed medications are to be administered within one hour of their prescribed time, unless otherwise specified.</p> <p>Review of Resident 115's clinical record revealed that the resident was readmitted to the facility on [DATE], with a Midline Catheter [tube placed into a vein in the upper arm to provide vascular access and for IV (intravenous- method to deliver fluids or medications directly into a vein using a needle or tube) treatments] and diagnoses to include urinary tract infection and sepsis (extreme immune response to infection that can lead to tissue damage, organ failure, or death if not treated right away).</p> <p>A physician order dated August 8, 2024, at 12:44 PM was noted for Ceftriaxone (an antibiotic used to treat bacterial infections) 1000 MG intravenously two times per day for urinary tract infection for three days.</p> <p>Review of a Scheduling Detail Report dated August 8, 2024, noted that the first dose was to be administered on August 8, 2024, at 10:00 PM.</p> <p>Review of Resident 115's Medication Administration Record dated August 8, 2024, through August 11, 2024, revealed that the physician ordered intravenous antibiotic medication, Ceftriaxone, was not administered to the resident on August 8, 2024, at 10:00 PM as prescribed.</p> <p>A nurse progress note dated August 8, 2024, noted that the scheduled 10:00 PM dose was not administered due to awaiting delivery from pharmacy.</p> <p>Interview with the Director of Nursing (DON) on August 15, 2024, at 12:00 PM, confirmed that the facility failed to timely administer the first dose of the IV antibiotic therapy prescribed for Resident 115, and failed to notify the attending physician of the missed dose on August 8, 2024.</p> <p>Refer F755</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy services</p> <p>(continued on next page)</p>		

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F 0694  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services  28 Pa. Code 211.10 (a)(c)(d) Resident care policies

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>41460</p> <p>Based on observations, clinical record review and staff interview it was determined that the facility failed to ensure the ready availability of necessary emergency supplies for a resident receiving hemodialysis for one of 16 residents sampled. (Resident 6)</p> <p>Findings include:</p> <p>According to the National Kidney Foundation patients receiving hemodialysis (a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) should keep emergency care supplies on hand.</p> <p>A review of Resident 6's clinical record revealed that the resident was admitted to the facility was on June 10, 2022, with diagnoses that included end stage renal disease (a chronic kidney disease that occurs when the kidneys can no longer function properly) and dependence on renal dialysis.</p> <p>Review of the resident's current plan of care, dated June 11, 2022, and last revised May 22, 2024, revealed that the resident required dialysis related to end stage renal failure along with a care planned approach to have emergency clamp kept at bedside for access site, check access site daily fistula/graft/catheter left forearm for signs of infection, and observe thrill and bruit and document findings, report abnormal findings to physician.</p> <p>Observation conducted on August 13, 2024, at 11:55 AM revealed that there were no emergency supplies available in the resident's room or on the resident's wheelchair.</p> <p>Interview with Employee 2, registered nurse, on August 13, 2024, at 11:58 AM, confirmed that no emergency supplies for Resident 6's dialysis access site were available in the resident's room or on her wheelchair. Employee 2 further confirmed that the emergency supplies were to be available at the bedside.</p> <p>Interview with the Director of Nursing on August 15, 2024, at approximately 1:45 PM confirmed the facility failed to ensure the ready availability of necessary emergency supplies at the resident's bedside and that the care plan reflected the required plan of care for the dialysis access site in the event of an emergency.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing Services</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39929</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure each resident received the necessary behavioral health care in a timely manner to attain or maintain the highest practicable mental and psychosocial well-being for one of 15 residents sampled (Resident 59).</p> <p>Findings include:</p> <p>A review of Resident 59's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including unspecified dementia (a loss of cognitive functioning that can make it difficult for someone to perform daily activities).</p> <p>Further review of Resident 59's clinical record revealed that the resident exhibited behaviors, including making statements regarding suicidal ideations.</p> <p>Review of Resident 59's care plan, initiated by the facility on May 18, 2024, did not indicate that the resident had a behavioral problem. The resident's care plan did not address the resident's specific behavioral problems or symptoms that were noted in the nursing documentation.</p> <p>Review of a Psychological evaluation dated June 6, 2024, indicated that Resident 59 was making statements of wanting to kill herself. Recommendations indicated that Resident 59 would benefit from continued psychological services.</p> <p>A review of a nursing progress note dated August 13, 2024, revealed the resident had told her daughter she wanted to kill herself. Further review of the resident's clinical record revealed that the physician was made aware of these statements, however social services, and psychological services were not made aware of these statements.</p> <p>The facility failed to update to the resident's care plan to address the mental health needs of the resident after she was voicing thoughts of harming herself.</p> <p>During an interview with the Nursing Home Administrator (NHA), on August 15, 2024, at approximately 10:00 AM, the NHA was unable to provide evidence that Resident 59 was being provided psychological services to maintain the highest practicable level of mental and psychosocial wellbeing.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(5) 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> 21738</p> <p>Based on review of clinical records and staff interview it was determined that the facility failed to provide pharmacy services to assure timely receiving of a prescribed antibiotic medication for one resident out of 16 residents reviewed (Resident 115).</p> <p>Findings include:</p> <p>Review of clinical record revealed that Resident 115, was readmitted to the facility on [DATE], with diagnoses to include urinary tract infection and sepsis (extreme immune response to infection that can lead to tissue damage, organ failure, or death if not treated right away).</p> <p>A physician order dated August 8, 2024, at 12:44 PM was noted for Ceftriaxone (an antibiotic used to treat bacterial infections) 1000 MG intravenously (a method of administering a substance, such as medicine or fluid, into a vein through a needle or tube) two times per day for urinary tract infection for three days.</p> <p>Review of a Scheduling Detail Report dated August 8, 2024, noted that the first dose was to be administered on August 8, 2024, at 10:00 PM.</p> <p>Review of Resident 115's Medication Administration Record dated August 8, 2024, through August 11, 2024, revealed that the physician ordered intravenous antibiotic medication, Ceftriaxone, was not administered to the resident on August 8, 2024, at 10:00 PM as prescribed.</p> <p>Interview with the director of nursing on August 15, 2024, at 12:00 PM confirmed the facility failed to timely provide Resident 115's first dose of intravenous antibiotic medication as prescribed because it was not available in the facility as the facility's pharmacy did not timely deliver the antibiotic drug.</p> <p>Refer F694</p> <p>28 Pa. Code 211.9 (a)(l)(d)(k) Pharmacy Services.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing Services.</p>

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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 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>21738</p> <p>Based on observation and staff interview, it was determined that the facility failed to properly dispose of garbage and refuse.</p> <p>Findings include:</p> <p>Observation on August 13, 2024, at 10:20 AM in the presence of the food service director revealed that the facility's dumpster, containing bags of garbage, was not covered. One of the two lids on the dumpster was observed open. There were food containers and debris scattered on the ground surrounding the dumpster.</p> <p>Interview with the food service director at this time confirmed that the dumpster lid was to be kept closed and that the area surrounding the dumpster should be maintained in a sanitary manner.</p> <p>28 Pa Code 201.8 (e)(2.1) Management</p>