

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER Lecom at Elmwood Gardens, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2628 Elmwood Avenue Erie, PA 16508	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, and staff interview it was determined that the facility failed to develop a comprehensive care plan for one of 13 residents reviewed (Resident R27). Findings include: A facility policy dated 3/20/24, entitled Care Plans indicated that the facility will develop a comprehensive care plan for each resident that includes measurable objectives, and timetables to meet residents medical, nursing, and mental / psychosocial needs of the resident. Resident R27's clinical record revealed an admitted [DATE], with diagnoses that included diabetes, transient ischemic attack (TIA - minor stroke or mini-stroke with noticeable symptoms going away) and obstructive sleep apnea (a disorder that makes you stop breathing repeatedly during sleep). Resident R27's clinical record revealed a physician's order 1/15/24, for Seroquel (psychotropic medication - affects the mind) 25 milligram (mg) by mouth at bedtime for depression and anxiety. Another physician's order dated 3/6/24, indicated the Seroquel dosage was increased to 50 mg at bedtime for delusions. The clinical record lacked evidence that a care plan had been developed to address Resident R27's behaviors and use of Seroquel. During an interview on 3/28/24, at 11:14 a.m. confirmed that a care plan had not been developed to address Resident R27's behaviors and use of Seroquel. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(3)(5) Nursing services		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to provide evidence that non-pharmacological interventions (interventions attempted to calm a resident other than medication) were attempted prior to the administration of a PRN (as needed) psychotropic (affecting the mind) medication for one of five residents reviewed for unnecessary medications (Resident R158). Findings include: A facility policy dated 3/20/24, entitled Unnecessary Drugs indicated that non-pharmacological interventions are considered and used when indicated. Review of Resident R158's clinical record revealed an admitted [DATE], with diagnoses that included anxiety, depression, and gastro-esophageal reflux disease (a condition where stomach acid flows back into the esophagus [tube that passes food from the mouth into the stomach]). Review of Resident R158's clinical record revealed a physician's order dated 3/19/24, that identified to administer Clonazepam (medication to treat anxiety) 1 milligram (mg) by mouth every 8 hours as needed for anxiety until 4/2/24. Review of Resident R158's Medication Administration Record (MAR) for March 2024 revealed that the PRN Clonazepam was used 18 times between 3/19/24, and 3/28/24. Review of the March 2024 MAR and clinical record progress notes revealed that there was no evidence of non-pharmacological interventions were attempted prior to the administration of the PRN Clonazepam 18 of the 18 times the Clonazepam was utilized in March 2024. During an interview on 3/28/24, at approximately 2:22 p.m. the Director of Nursing confirmed that there was no evidence of non-pharmacological interventions being attempted prior to the administration of the PRN Clonazepam 18 of the 18 times it was administered to Resident R158 between 3/19/24, and 3/28/24. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 201.18(b)(1)(3) Management		