

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Laureldale Skilled Nursing and Rehabilitation Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 Elizabeth Avenue Laureldale, PA 19605	

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>36935</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident's representative(s) of transfer and the reasons for the move in writing for nine of 12 sampled residents who were transferred to the hospital. (Residents 2, 4, 13, 14, 15, 18, 83, 130, 155)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 2 was transferred and admitted to the hospital on March 9, 2024, after a change in condition. There was no evidence that the resident's responsible party was provided with written information regarding the resident's transfer to the hospital.</p> <p>Clinical record review revealed that Resident 4 was transferred and admitted to the hospital on March 27, 2024, after a change in condition. There was no evidence that the resident's responsible party was provided with written information regarding the resident's transfer to the hospital.</p> <p>Clinical record review revealed that Resident 13 was transferred and admitted to the hospital on May 30, 2024, after a change in condition. There was no evidence that the resident's responsible party was provided with written information regarding the resident's transfer to the hospital.</p> <p>Clinical record review revealed that Resident 14 was transferred and admitted to the hospital on May 5, 2024, after a change in condition. There was no evidence that the resident's responsible party was provided with written information regarding the resident's transfer to the hospital.</p> <p>Clinical record review revealed that Resident 15 was transferred and admitted to the hospital on April 17, 2024, after a change in condition. There was no evidence that the resident's responsible party was provided with written information regarding the resident's transfer to the hospital.</p> <p>Clinical record review revealed that Resident 18 was transferred and admitted to the hospital on May 18, 2024, after a change in condition. There was no evidence that the resident's responsible party was provided with written information regarding the resident's transfer to the hospital.</p> <p>Clinical record review revealed that Resident 83 was transferred and admitted to the hospital on April 4, 2024, after a change in condition. There was no evidence that the resident's responsible party was provided with written information regarding the resident's transfer to the hospital.</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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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review revealed that Resident 130 was transferred and admitted to the hospital on May 17, 2024, and June 5, 2024, after changes in condition. There was no evidence that the resident's responsible party was provided with written information regarding the resident's transfers to the hospital.</p> <p>Clinical record review revealed that Resident 155 was transferred and admitted to the hospital on May 9, 2024, after a change in condition. There was no evidence that the resident's responsible party was provided with written information regarding the resident's transfer to the hospital.</p> <p>In an interview on June 27, 2024, at 1:07 p.m., the Director of Nursing confirmed that written transfer information, including the reasons for the move, was not provided to residents' representatives.</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>48578</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that physician's orders were implemented for two of 35 sampled residents. (Residents 135, 151)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 135 had diagnoses that included history of a stroke and high blood pressure. On June 1, 2024, a physician's order directed staff to administer a medication (metoprolol tartrate) two times a day to treat the resident's high blood pressure and heart rate. Staff was not to give the medication if the resident had a systolic (top number of a blood pressure reading) blood pressure below 110 millimeters of mercury (mmHg) or if the heart rate was less than 50 beats per minute. A review of the June 2024, Medication Administration Record (MAR) revealed that staff administered the medication over 43 times without checking that the blood pressure and heart rate were above the hold parameters.</p> <p>Clinical record review revealed that Resident 151 had diagnoses that included sepsis, kidney failure, and heart failure. On May 31, 2024, a physician's order directed staff to administer a medication (furosemide) one time a day on Mondays, Wednesdays, and Fridays, and to hold the medication if the blood pressure readings were below 90/60 mmHg. A review of the resident's June 2024, MAR revealed that staff administered the medication ten times in June 2024, without confirming that the blood pressure was above the established parameter.</p> <p>In an interview on June 27, 2024, at 12:00 p.m., the Director of Nursing confirmed the parameters were not checked prior to the administration of the medications for Residents 135 and 151.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36935</p> <p>Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide restorative nursing services to prevent a reduction in range of motion and/or to improve or maintain mobility on a consistent basis for three of 35 sampled residents. (Residents 4, 31, 83)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 4 had diagnoses that included dementia, congestive heart failure, and hemiplegia (one sided paralysis or weakness). The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was cognitively impaired and required staff assistance for activities of daily living. Review of Resident 4's current care plan revealed that she was at risk for loss of range of motion due to her physical limitations and that staff was to provide a restorative nursing program for passive range of motion exercises to her legs with morning and evening care. There was no documented evidence to support that staff was completing passive range of motion exercises to Resident 4's legs.</p> <p>Clinical record review revealed that Resident 31 had diagnoses that included dementia and pain in the left and right knee. The MDS assessment dated [DATE], indicated the resident was cognitively impaired and required staff assistance for activities of daily living. Review of Resident 31's care plan revealed that he was at risk for loss of range of motion with an intervention for staff to provide restorative passive range of motion exercises to his legs with morning and evening care. There was no documented evidence that staff was completing the passive range of motion exercises for Resident 31.</p> <p>Clinical record review revealed that Resident 83 had diagnoses that included chronic obstructive pulmonary disease and anxiety. The MDS assessment dated [DATE], indicated that the resident required staff assistance for activities of daily living. Review of Resident 83's current care plan revealed that she was at risk for loss of range of motion due to physical limitations and that that staff was to provide a restorative nursing program for passive range of motion to her right arm with morning and evening care. In an interview on June 26, 2024, at 10:30 a.m., Resident 83 stated that staff do not complete exercises to her right arm. There was no documented evidence to support that staff was completing passive range of motion exercises to Resident 83's right arm.</p> <p>In an interview on June 27, 2024, at 11:57 a.m. the Director of Nursing confirmed that there was no documented evidence that the restorative nursing programs were completed.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36935</p> <p>Based on clinical record review, review of facility documentation, observation, and staff interview, it was determined that the facility failed to provide adequate supervision to prevent accidents/hazards on two of four nursing units. (Second Floor Unit and Third Floor Unit) In addition, it was determined that the facility failed to thoroughly investigate a fall and provide appropriate interventions for one of six sampled residents identified at risk for falls. (Resident 56)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 9 had diagnoses that included gastro-esophageal reflux disease, dementia, and spinal stenosis. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had cognitive impairment. On January 18, 2024, the physician ordered a dysphagia mechanically altered texture diet. Review of Resident 9's care plan revealed she had a self-care deficit with an intervention for staff to provide meal support. Observations on June 26, 2024, from 12:38 p.m. through 12:50 p.m., revealed Resident 9 in bed in room [ROOM NUMBER] with Resident 28 assisting to feed Resident 9 her lunch. At no time did staff intervene.</p> <p>Observations on June 27, 2024, from 11:30 a.m. to 11:45 a.m., revealed that the third floor unit treatment cart was opened and unlocked. The cart contained tubes of medications, including three tubes of steroid creams, two tubes of antibiotic creams, two bottles of antifungal medications, one tube of hemorrhoid relief cream, and one tube of pain relief cream. Cognitively impaired residents, including Residents 56 and 88, were observed walking around the unit and self-propelling around the unit without supervision at this time.</p> <p>In an interview on June 27, 2024, at 11:45 a.m., the third floor unit manager confirmed the drawer on the treatment cart should have been locked.</p> <p>Clinical record review revealed that Resident 56 was admitted to the facility with diagnoses that included dementia, anxiety, and diabetes mellitus. Review of the MDS assessment dated [DATE], indicated that the resident had multiple falls and used an indwelling urinary catheter (a device used to drain urine when you cannot urinate on your own). Review of the current care plan revealed that Resident 56 was at risk to fall due to unsteady walking and behaviors and an intervention was for the resident's bed to be kept in a low position. After a fall on April 9, 2024, documentation on the facility incident report and care plan revealed that the intervention added to prevent further falls was to toilet the resident for urinary incontinence, even though the resident had a urinary catheter in place. On April 24, 2024, Resident 56 was again found on the floor next to his bed. Review of the nursing notes and the facility incident report did not indicate if Resident 56's bed was in a low position when he fell. Review of the facility incident report and an interdisciplinary team note dated April 24, 2024, revealed that the intervention was to educate nursing staff on maintaining the resident's bed in a low position.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on June 27, 2024, at 1:00 p.m. the Director of Nursing confirmed that Resident 56 used an indwelling urinary catheter and would not be appropriate for a toileting program to prevent falls. The Director of Nursing also stated that there was no documentation to support that Resident 56's bed was in the low position when he fell out of bed on April 24, 2024.</p> <p>CFR. 483.25(d)(1)(2) Accidents.</p> <p>Previously cited 8/24/23</p> <p>28 Pa. Code 211.12(d)(5) Nursing services.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45244</p> <p>Based on clinical record review, observation, and resident interview, it was determined that the facility failed to accommodate each resident's preference at meal times for two of 35 sampled residents. (Residents 21, 130)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 21 had diagnoses that included diabetes, gastro-esophageal reflux disease (GERD), and problems with the intestines. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the resident was alert and oriented. Review of Resident 21's care plan revealed she had potential for a nutritional problem related to diabetes, GERD, and intestinal issues. Observation on June 26, 2024, from 12:40 p.m. through 12:55 p.m., revealed Resident 21 with her lunch tray. Resident 21's meal ticket stated she was not to have gravy on any part of her meal. Resident 21 was observed with three ounces of roast pork that was heavily coated with a dark brown gravy. In an interview on June 26, 2024, at 12:45 p.m., Resident 21 stated she did not like gravy.</p> <p>Clinical record review revealed that Resident 130 had diagnoses that included dementia, underweight, and malnutrition. Review of the MDS assessment dated [DATE], revealed the resident had cognitive impairment. Review of Resident 130's care plan revealed she had potential for a nutritional problem related to poor appetite. Observation on June 26, 2024, from 12:17 p.m. through 12:40 p.m., revealed Resident 130 with her lunch tray. Resident 130's meal ticket stated she would receive carrots. The menu for the day included broccoli. Resident 130 was observed with broccoli on her plate.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b) Management.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36935</p> <p>Based on observation, it was determined that the facility failed to maintain sanitary conditions in the kitchen.</p> <p>Findings include:</p> <p>Observation during the environmental tour on June 25, 2024, at 8:30 a.m., revealed three pipes covered in dust lying on the floor near the ice machine. There were two dirty bowls behind the ice machine, and water was observed draining from the ice machine onto the floor underneath and around the ice machine, creating areas of standing water. In the dish room, there was a vent with various areas of peeling paint.</p> <p>28 Pa. Code 201.18(e)(2.1) Management.</p>		