

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Gwynedd Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 773 Sumneytown Pike Lansdale, PA 19446	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>48347</p> <p>Based on a review of facility policies, facility documentation, review of clinical records and interviews with residents and staff, it was determined that the facility failed to conduct a thorough investigation related to potential resident abuse and/or neglect related to an injury during resident care for one of eight residents reviewed. (resident R 121)</p> <p>Findings include:</p> <p>Review of facility policy titled Reporting and Investigating Resident Accident/ Incident Policy and Procedure reviewed November 2018 revealed that all occurrences which are not consistent with the routine operation of the facility and care of residents that have or may cause physical injury or harm will be reported, reviewed, and investigated. All accidents/ incidents must be reported the supervisor must immediately examine the resident, the appropriate accident incident and investigation report must be completed, the resident's representative and attending physician will be notified, all accidents slash incidents will have an investigation conducted by the supervisor, upon completion of the investigation report it must be determined if there is reasonable cause to believe that abuse has occurred. Reasonable cause is defined as meeting that upon review of the circumstances, there is sufficient evidence for a prudent person to believe that physical abuse, mistreatment, or neglect has occurred. If there is reasonable cause, a resident abuse report must be completed. The unit manager must review the report for completeness and assure all notifications have been made, the complete report will be reviewed and discussed by the interdisciplinary team, a completed report includes revision of the resident's care plans to confirm interventions implemented as a result of the incident and for prevention of further incidents.</p> <p>Review of facility policy titled Abuse of Residents revised October 27, 2022, revealed It is a policy of the facility that acts of physical verbal psychological and financial abuse directed against residents are absolutely prohibited. Resident has the right to be free from verbal sexual physical and mental abuse, corporal punishment, involuntary seclusion, mistreatment, neglect, exploitation, and misappropriation of property. Residents shall not be subjected to abuse by anyone included but not limited to staff other residents' consultants, volunteers, staff from other agencies, family members or legal guardians, friends or other individuals.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of this policy revealed the definition of neglect is defined as the failure of the facility its employees or service providers to provide goods and services to a resident that are necessary to avoid harm pain mental anguish or emotional distress. Neglect occurs when the facility is aware of or should have been aware of goods or services that a resident requires but the facility fails to provide them to the resident, that has resulted in or may result in physical harm, ping, mental anguish, or emotional distress. Neglect includes cases where the facilities indifference or disregard for resident care comfort or safety resulted in or could have resulted in physical harm pain, mental anguish, or emotional distress. Neglect may be the result of a pattern of failures or maybe the result of one or more failures involving one resident and one staff person.</p> <p>Abuse prevention components include screening of new employee for any history of abuse, training employees receive education related to abuse neglect exploitation and misappropriation of resident property upon higher as part of orientation and annually, and identification as an ongoing assessment and care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to a conflict or neglect.</p> <p>Upon receiving an incident or suspected incident of resident abuse or neglect the administrator, director of nursing, and or designee will conduct an investigation to include but not limited to the following; complete designate report form for investigation, interview the person's reporting the incident, interview any witnesses to the incident, Interview the resident's roommates, family members and visitors, interview other residents to which the accused employee provides care services, and review all circumstances surrounding the incident .</p> <p>Review of Resident R121's clinical record revealed that this resident entered the facility January 28, 2022 with diagnosis's including cerebral infarction (stroke) and Hemispheres (a condition that causes weakness or inability to move one side of the body). Resident R121 possessed right sided dominant impairment requiring use of a wheelchair and moderate assistance for activities of daily living (ADL) as well as standing and transfers.</p> <p>Further review of Resident R 121's clinical record revealed that Resident R121 was assessed to possess a Brief Interview of mental status (BIMS a standardized assessment tool to evaluate a patient cognitive functioning), score of fourteen indicating this resident's cognition is intact.</p> <p>Review of physical therapy notes dated April 8, 2024 revealed that Resident R121that the resident's functional status for transfers was sit to stand requiring partial moderate assistance (pull to stand inside bars).</p> <p>Review of facility documentation reported to the State Agency dated April 9, 2024, approximately at 9:15 p. m. Resident R121 was standing with assistance from nursing aide, Employee E7 when she became weak and fell back. The nurse aide, Employee E7 was unable to catch the resident to prevent the resident from falling. Resident R121 sustained a laceration to her right eyebrow which required seven sutures.</p> <p>Review of facility investigation revealed statement written by nurse iade, Employee E7, stated that the resident got up and held on to the bed frame while the nursing assistant was providing care. She fell back into my arms and fell to the floor.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the investigation revealed Resident R121's statement I was in my wheelchair, and she was going to change my diaper. She pushed my wheelchair to the end of the bed I stood up and she pulled down my pants and took off my diaper. I started to fall backwards. Did not have time to catch me.</p> <p>Continued review of this investigation included statements from other staff members that have provided care to Resident R 121. Statement from Licensed nurse, Employee E8 revealed that this resident was an assist of one with incontinence care. Stands at the bar in the bathroom to have care provided.</p> <p>Statement written from Licensed nurse, Employee E9 completed a statement that the mechaical lift and two persons assist all times for transfer. Resident only stands from the wheelchair in the bathroom or hallway normally when she holds on to the rail or grabs the bar in the bathroom with a warm person assist.</p> <p>Statement written from nurse aide, Employee E10, revealed I changed her brief in the bathroom she stands with one assist holding onto the rail with her wheelchair directly behind her.</p> <p>Review of statement provided from nurse aide, Employee E6 revealed that he was called to the room for help and observed that Resident R121 had fallen.</p> <p>Statement provided by Social worker, Employee E5 on April 10, 2024, confirmed that Resident R121 was knowledgeable that she should be changed in the bathroom or shower room, but this interview revealed she preferred to change at bedside.</p> <p>The facility failed to conduct a through investigation including length of time the resident was standing, where her wheelchair was located at time of fall, interview with two other roommates in the room at time of incident, and interview with maintenance to determine the structure of bedframe.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.29 (a) Resident rights</p>		

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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>48347</p> <p>Based on review of facility policies, clinical record reviews, and interviews with staff, it was determined that the facility failed to develop and implement a comprehensive person centered care plan related to incontinent care for one of eight residents reviewed.(resident R121)</p> <p>Findings include:</p> <p>Review of facility policy titled Care plans, comprehensive person centered Revealed a comprehensive, persons and our care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care planned interventions are derived from a thorough analysis of the information gathered is a part of the comprehensive assessment. The comprehensive persons care plan includes measurable objectives and time frames, describes the services that are to be furnished to attain them or maintain the residents highest practical physical mental and psychosocial well-being, includes the residents' dated goals, builds on the resident strengths, and reflects currently recognized standards of practice for problem areas and conditions.</p> <p>Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of the residents are ongoing and care plans are revised as information about residents and the residents' conditions changes.</p> <p>Review of facility policy titled Reporting and Investigating Resident Accident/ Incident Policy and Procedure reviewed November 2018 revealed that all occurrences which are not consistent with the routine operation of the facility and care of residents that have or may cause physical injury or harm will be reported, reviewed, and investigated. All accidents/ incidents must be reported the supervisor must immediately examine the resident, the appropriate accident incident and investigation report must be completed, the resident's representative and attending physician will be notified, all accidents slash incidents will have an investigation conducted by the supervisor, upon completion of the investigation report it must be determined if there is reasonable cause to believe that abuse has occurred. Reasonable cause is defined as meeting that upon review of the circumstances, there is sufficient evidence for a prudent person to believe that physical abuse, mistreatment, or neglect has occurred. If there is reasonable cause, a resident abuse report must be completed. The unit manager must review the report for completeness and assure all notifications have been made, the complete report will be reviewed and discussed by the interdisciplinary team, a completed report includes revision of the resident's care plans to confirm interventions implemented as a result of the incident and for prevention of further incidents.</p> <p>Review of Resident R121's clinical record revealed that this resident entered the facility January 28, 2022 with diagnoses including cerebral infarction (stroke) hemiplegia (a condition that causes partial or complete paralysis to one side of the body), and Hemispheres (a condition that causes weakness or inability to move one side of the body). Resident R121 possessed right sided dominant impairment requiring use of a wheelchair and moderate assistance for activities of daily living (ADL) as well as standing and transfers.</p> <p>(continued on next page)</p>		

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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>Continued review of Resident R121's clinical record revealed that Resident R121 was assessed to possess a Brief Interview of Mental status (BIMS a standardized assessment tool to evaluate a patient cognitive functioning), score of 14 indicating this resident's cognition is intact.</p> <p>Continued review of Resident R121's clinical record revealed that Resident R121 sustained an injury on April 9, 2024, while receiving toileting care at bedside. Resident R121 was using the bedframe/ foot board as a grab bar for support. The investigation concluded that is was within Resident R121, resident rights to choose to be toileted at bedside.</p> <p>Review of Resident R121's care plan revealed The resident has decreased stability during mobility decreased strength balance and activity tolerance data initiated October 1, 2024 with interventions to include patient will be reminded to Donn and Doff gloves while performing wheelchair mobility, Resident R 121 has potential alteration and bowel and bladder elimination related to incontinence data initiated April 1, 2023, interventions include call light within reach, and encourage resident consume all fluids monitor from redness and skin breakdown, and provide skin care after each incontinent episode and implied a moisture barrier.</p> <p>Continued review of Resident R121's care plan revealed that Resident R 121 has potential for falls related to decreased mobility dated April 1, 2023, interventions include anticipate and meet the residents needs, monitor for toileting needs, place residents call light within reach, provide a safe environment, provide resident and caregiver education for safe techniques, provide verbal cues for proper pacing and energy conservation techniques, therapy screen and evaluation as needed. Resident R121 demonstrates decreased ability to perform ADL's (activities of daily living) due to muscle weakness and deconditioning interventions include resident is a two person assist with bed mobility initiated November 17, 2023 with interventions including; resident is a two person assist with transfers dated November 17, 2023, resident requires one assist with standing holding on to the rail in the bathroom or shower room initiated April 10, 2024 and the resident requires assistance from staff for transfers initiated April, 2023.</p> <p>Interview with NHA Employee E 1, on November 14, 2024 confirmed that Resident R 121's care plan has not been updated with resident preferences and proper safe instruction regarding toileting needs which included to be toilet at at bedside.</p> <p>28 Pa. Code 211.11(d) Resident Care Plan</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 - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46508</p> <p>Based on observations, review of facility policies and interviews with staff, it was determined that the facility failed to store, food in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <p>Review of facility policy on Receiving revealed that under section Policy Statement, Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery and subsequent storage of all food.</p> <p>Under section Procedures #5 All food items will be appropriately labelled and dated either through manufacturer packaging or staff notation. #8. The Dining Services Director is responsible for following distributor instructions for all applicable products</p> <p>Observation of the kitchen conducted on November 12, 2024, at 9:09 am with the Director of Dietary, Employee E3 revealed the following:</p> <p>One plastic bag containing hamburger buns had a sticker with date delivered of 10/13. Further best by date was not written on the sticker.</p> <p>One plastic bag containing hamburger buns was not labelled with date delivered and was not labelled with best by date.</p> <p>One plastic bag containing hamburger buns was not labelled with date delivered and was not labelled with best by date. Further observation of the plastic bag revealed that four of the hamburger buns in the plastic bag had grayish green powdery matter at the bottom of the hamburger buns.</p> <p>One plastic bag containing hotdog buns was not labelled with date delivered and was not labelled with best by date.</p> <p>Interview with Director of Dietary, Employee E3 conducted at the time of the investigation confirmed the above observations.</p> <p>Further, Director of Dietary, Employee E3 removed the four bags and Employee E3 revealed that he discarded the four bags. Director of Dietary, Employee E3 also revealed that all bags should have been labelled with the delivery date and best by date</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		