| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395489 | A. Building<br>B. Wing | 11/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Corry Manor | 640 Worth Street<br>Corry, PA 16407 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496<br><br>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to ensure the physician orders and Pennsylvania Orders for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments) were consistent for one of 25 residents reviewed (Resident R80).<br><br>Findings include:<br><br>Review of facility policy entitled Advance Directives Policy - PA dated [DATE], indicated General Policies All decisions to withhold or withdraw treatment or services . are subject to the following policies:<br><br>2. Documentation<br><br>b. The physician's order should also be noted on the resident's plan of care and on the inside of the resident's clinical record.<br><br>Review of Resident R80's clinical record revealed an admitted [DATE], with diagnoses that included Diabetes (a health condition that caused by the body's inability to produce enough insulin), Dementia (a disease that affects short term memory and the ability to think logically), and Hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones).<br><br>Review of Resident R80's clinical record revealed two POLST forms with the first one dated [DATE], signed by the physician [DATE], for Cardiopulmonary Resuscitation (CPR-emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest)- Full Code. The second POLST dated [DATE], with no evidence of a physician signature for Do Not Attempt Resuscitation (DNR- allow natural death).<br><br>During an interview on [DATE], at 9:25 a.m. Licensed Practical Nurse (LPN) Employee E1 revealed that during an emergent situation the staff refer to resident's paper chart to determine resident life sustaining wishes. LPN Employee E1 confirmed that Resident R80's POLST lacked evidence of a physician signature reflecting his/her wishes for DNR. He/she also confirmed that Resident R80's POLST should have been signed by the physician to reflect Resident R80's current wishes.<br><br>28 Pa. Code 201.18 (b)(1) Management<br><br>(continued on next page) |

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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 28 Pa. Code 201.29(a) Resident rights<br><br>28 Pa. Code 211.5(f)(i) Medical records<br><br>28 Pa. Code 211.10(c) Resident care policies |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655<br><br>Based on observation, review of facility and clinical records, and staff and resident interviews it was determined that the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior for one resident (Resident R36) and maintain sanitary resident specific equipment for one resident (Resident R4) of 25 residents reviewed.<br><br>Findings include:<br><br>No facility policy provided.<br><br>Resident R36's clinical record revealed an admitted [DATE], with diagnoses that included end-stage renal disease, dependence on renal dialysis, right below the knee amputation, and peritonitis (life-threatening condition that occurs when the peritoneum, the tissue that lines the abdomen, becomes inflamed or infected), and a physician's order dated 10/30/24, to set up, prime, and run cycler with two-six liter yellow bags Sunday, Tuesday, Wednesday, Friday, and Saturday.<br><br>Observation on 11/04/24, at 3:40 p.m. of Resident R36's room revealed one full dialysate (fluid used in dialysis to exchange solutes with the blood and remove waste products from the body) drainage bag in a blue plastic tote, one empty dialysate infusion bag and tubing on the floor, and one empty dialysate infusion bag on the scale on the bedside stand.<br><br>During an interview at that time, Resident R36 confirmed that the dialysis comes down on night shift, early in the morning and this stuff should have been cleaned up by now.<br><br>During an interview on 11/04/24, at 3:53 p.m. Licensed Practical Nurse (LPN) Employee E7 confirmed that Resident R36's full dialysate drainage bag should have been emptied and that all three bags should have been discarded in the hazard waste.<br><br>Resident R4's clinical record revealed an admitted [DATE], with diagnoses including parkinsonism (a clinical condition caused by brain disorders, brain injuries, or certain drugs and toxins), psychotic disorder with delusions (a brief or altered reality with a belief in something that is untrue), fracture of left pubis (a type of crack or break in a person's pelvis), and lack of coordination.<br><br>Observation on 11/04/24, at 1:05 p.m. revealed Resident R4 sitting in his/her wheelchair with layers of dirty and dried food covering the metal frame of the wheelchair. Further observations on 11/06/24, at 12:40 p.m. revealed Resident R4's wheelchair in the same unsanitary condition as noted above.<br><br>An interview on 11/06/24, at 12:40 p.m. LPN Employee E6 confirmed Resident R4's wheelchair was unsanitary with layers of dirty dried food on it, and should have been cleaned for Resident R4.<br><br>28 Pa. Code 201.18 (b)(1)(3) Management<br><br>28 Pa. Code 201.14(a) Responsibility of licensee |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31185<br><br>Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive person-centered care plans for each resident that included measurable objectives and timetables to meet a resident's needs for one of 25 residents reviewed (Resident R95) and for one of five residents reviewed with an indwelling catheter (tube inserted into the bladder to drain urine) (Closed Record Resident CR12).<br><br>Findings include:<br><br>A facility policy entitled, Comprehensive Care Plan, dated 12/26/23, indicated the facility will develop a comprehensive person centered care plan for each resident that includes measurable objective and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment, and include: services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; be developed within seven days after the completion of the comprehensive assessment, prepared by the interdisciplinary team, be periodically reviewed and revised by a team of qualified personal after each assessment, and provide services that meet professional standards of quality.<br><br>Review of Resident R95's clinical record revealed an admitted [DATE], with diagnoses that included compression fracture of unspecified lumbar vertebra, pain in left hip, low back pain and major depressive disorder.<br><br>Review of Resident R95's admission assessment dated [DATE], indicated that Resident R95 was a Full Code (all life sustaining measures to be done if resident is without pulse and respirations) and also revealed the resident had severe pain in the left hip and back. Admission physician's orders for Resident R95 revealed an order for weekly weight times four weeks then monthly and as needed. A physician's order dated 9/30/24, revealed an order for weekly standing weight per request every seven days. Review of Resident R95's weights revealed one documented weight on 6/22/24, and documented refusals thereafter.<br><br>Clinical record review for Resident R95 revealed consistent multiple refusals of care including weights, showers, out of facility appointments and behaviors of yelling, screaming, demanding pain medications and calling 911 to go to hospital for pain.<br><br>Review of Resident R95's person centered plans of care revealed only a plan of care for nutrition dated 6/25/24. The care plan for Code Status wasn't developed until 10/23/24; the Pain, Skin breakdown and Self Care deficit care plans weren't developed until 10/30/24. The Impaired Coping Mood Disorder and Behavior Management, New disruptive behavior and New refusal of care plans were recently developed on 11/04/24.<br><br>During an interview on 11/06/24, at 9:50 a.m. the Nursing Home Administrator confirmed that Resident R95's comprehensive plans of care were not completed timely after admission.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident CR12's clinical record revealed an admitted [DATE], with diagnoses that included stroke, hydronephrosis (condition where the kidneys swell and stretch due to a buildup of urine), epilepsy (chronic brain disorder that causes seizures, which are episodes of abnormal electrical activity in the brain), and hemorrhagic cystitis (urinary bladder lining becomes inflamed and bleeds) diagnosed [DATE].<br><br>Further review of Resident CR12's clinical record revealed no evidence that a care plan was developed for maintaining an indwelling catheter; departmental progress notes since 7/11/24; revealed five progress notes that included documentation of the presence of an indwelling catheter (9/24/24, 9/26/24, and 10/24/24); and monthly physician's progress notes (8/15/24, 9/26/24, 10/29/24) revealed documentation of the presence of an indwelling catheter.<br><br>During an interview on 11/07/24, at 8:16, a.m. the Director of Nursing confirmed that there was no comprehensive care plan developed for Resident CR 12 to address the indwelling catheter.<br><br>28 Pa. Code 201.14 (a) Responsibility of Licensee<br><br>28 Pa. Code 201.18 (b)(1)(3) Management<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832<br><br>Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to review and revise comprehensive care plans to reflect the current care and services for two of 25 residents reviewed (Residents R51 and R91).<br><br>Findings include:<br><br>Review of a facility policy entitled Comprehensive Care Plan dated 12/26/23, indicated that Periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>Resident R51's clinical record revealed an admitted [DATE], with diagnoses that included Hyperlipidemia (high cholesterol), Hypertension (high blood pressure), and Gastro Esophageal Reflux Disease (a condition when stomach acid repeatedly flows back up into your throat).<br><br>Review of Resident R51's Plans of Care revealed a plan of care for risk for skin breakdown with a target date (a date that the care plan is to be updated by) of 8/07/24.<br><br>During an interview with the Registered Nurse Assessment Coordinator (RNAC) on 11/06/24, at 1:10 p.m. he/she confirmed the care plan for Resident R51 was not reviewed/revised to reflect current resident care and services. He/she also confirmed that care plans should be reviewed and revised as necessary.<br><br>During an interview on 11/07/24, at 9:30 a.m. a family member of Resident R91 revealed Resident R91's plan of care has not been reviewed or revised, and no care plan meeting has taken place since May of 2024.<br><br>Review of Resident R91's clinical record lacked any evidence of a care plan meeting and care plan revisions/review since May 2024.<br><br>During an interview with the Regional Director of Clinical Services on 11/07/24, at 1:15 pm. he/she confirmed the care plan for Resident R91 was not reviewed/revised to reflect current resident care and services and no care plan meeting was conducted since May of 2024. He/she further confirmed that care plans should be reviewed and revised as necessary and care plan meetings should occur quarterly.<br><br>28 Pa. Code 211.10(c)(d) Resident care policies<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing services |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832<br><br>Based on review of clinical and hospital records, a review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual 2019 (RAI-assessment guide used to plan the provision of care for residents), and staff interviews, it was determined that the facility failed to provide needed care or services resulting in an actual or potential decline in one or more residents' physical, mental, and/or psychosocial well-being for one (Closed Record Resident (CR12) of five residents with an indwelling catheter (tube inserted into the bladder to drain urine) and reposition two of 25 residents reviewed (Residents R15 and R38).<br><br>Findings include:<br><br>A facility policy, entitled Quality of Care Policy/Activities of Daily Living, dated 12/26/23, revealed each resident will receive and the Manor will provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A resident's abilities in activities of daily living will not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. A resident who is unable to carryout activities of daily living receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene.<br><br>Resident R15's clinical record revealed an admitted [DATE], with diagnoses that included rheumatoid arthritis (a chronic inflammatory disorder affecting joints in the hands and feet), weakness, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to arms and legs), and anxiety.<br><br>Review of the RAI manual instructions for Section C0500 Brief Interview for Mental Status (BIMS) revealed that a score of 13-15 identified a resident as cognitively intact, and a score of 8-12 identified a resident as moderately impaired, and a score of 0-7 as severely impaired.<br><br>Review of a Minimum Data Set (MDS- periodic assessment of resident care needs) dated 9/30/24, under Section C0500 revealed that Resident R15 had a BIMS of 3/15, severe cognitive impairment.<br><br>Resident R15's MDS Section G - Functional Status dated 10/22/24, revealed Resident R15 required extensive assistance with two (+) persons physical assist for bed mobility and transfers.<br><br>Resident R15's care plan dated 7/10/24, revealed a focus as potential for (chronic) pain related to diseases and conditions including rheumatoid arthritis, weakness, impaired mobility, dry eye syndrome, on comfort measures, etc. with interventions included to provide non-pharmacological interventions (heat/cold, dim lighting, calm environment), turning and repositioning, offer food/fluids as per dietary order, diversional activities of choice, and decreased stimuli in environment, etc Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to signs/symptoms or complaints of pain or discomfort. Resident R15's care plan further revealed a focus as ADL Self Care Performance deficit with interventions as OT (Occupational Therapy) recommends out of bed to wheelchair daily with peri care every two hours due to incontinence/resident not indicating need to toilet. Transfer: require partial to moderate assistance from staff with transfers. Bed Mobility: partial to moderate assistance require one person extensive assist for bed mobility.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident R15's progress notes lacked evidence that Resident R15 was refusing to get out of bed on 11/04/24, 11/05/24, or 11/06/24.<br><br>Observations on 11/04/24, at 11:20 a.m., 1:35 p.m., 2:00 p.m., and 3:35 p.m. revealed Resident R15 in bed laying on his/her back.<br><br>Observations on 11/05/24, at 9:30 a.m., 11:00 a.m., 12:30 p.m., and 3:15 p.m. revealed Resident R15 in bed laying on his/her back.<br><br>Observations on 11/06/24, at 8:30 a.m., 9:30 a.m., 11:40 a.m., and 12:00 p.m. revealed Resident R15 in bed laying on his/her back.<br><br>An interview with the Registered Nurse Assessment Coordinator (RNAC) on 11/06/24, at 3:55 p.m. confirmed Resident R15 is a two (+) persons physical assist for bed mobility and transfers, and needs staff assistance to turn and reposition and should be out of bed to wheelchair daily as noted in care plan by OT.<br><br>Resident R38's clinical record revealed an admitted [DATE], with diagnoses that included protein-calorie malnutrition (a loss of appetite and lack of interest in food resulting in muscle wasting), hypertensive heart disease with heart failure (a group of conditions that can occur when high blood pressure damages the heart), chronic obstructive pulmonary disease (COPD - a group of lung disease that makes it difficult to breathe), and bradycardia (a condition where heart rate is slower than 60 beats per minute - low heart rate).<br><br>Review of an MDS dated [DATE], revealed that Resident R38 had a BIMS of 6/15, severe cognitive impairment.<br><br>Resident R38's MDS Section G - Functional Status dated 9/27/24, revealed Resident R15 requires extensive assistance with one-person physical assist for transfers.<br><br>Resident R38's care plan dated 6/26/24, revealed a focus at risk for alteration in comfort related to skin cancer to right cheek, pain in right shoulder, general malaise (a sense of being unwell often accompanied by fatigue and/or pain), high blood pressure, COPD, bradycardia, dysphagia (difficulty swallowing), gastroesophageal reflux disease (a disease in which stomach acid or bile irritates the food pipe lining), anemia (a condition in which the blood doesn't have enough red blood cells to carry oxygen throughout the body), and history of falls with interventions as allow sufficient rest periods, assist with mobility and positioning as needed and will receive pain management throughout stay at the facility including to be positioned for comfort, pain will be monitored, assessed and treated using the appropriate pain scale as needed.<br><br>Observations on 11/07/24, at 9:15 a.m. revealed Resident R38 out of bed sitting in his/her wheelchair.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observations on 11/07/24, at 11:10 a.m. revealed Resident R38 sitting in his/her wheelchair verbalizing to a staff member as the staff member walked past him/her, please can I get off my butt, it hurts so bad. Further observations between 11:10 a.m. and 11:50 a.m. revealed several staff members walking by Resident R38 with his/her arm reaching out to each staff member as they walked by him/her. Resident R38 was then observed in dining room at 11:53 a.m. for lunch and was still asking to be laid down due to her bottom hurting really bad. Resident R38 stated while sittng in dining room, I have been up since breakfast and my butt hurts so bad and they won't lay me down. This happens all the time.<br><br>An interview on 11/07/24, at 11:54 a.m. with Licensed Practical Nurse (LPN) Employee E6 confirmed that Resident R38 has been out of bed since breakfast and should have been laid down between meals due to Resident R38 eats in the dining room for all meals.<br><br>Resident CR12's clinical record revealed an admitted [DATE], with diagnoses that included stroke, hydronephrosis (condition where the kidneys swell and stretch due to a buildup of urine), epilepsy (chronic brain disorder that causes seizures, which are episodes of abnormal electrical activity in the brain), and hemorrhagic cystitis (urinary bladder lining becomes inflamed and bleeds) diagnosed [DATE].<br><br>A physician's order for an indwelling catheter size 18 French with a 15-cc [cubic centimeter] balloon was discontinued on 11/05/23, and there was no evidence that Resident CR12 had an active physician's order for an indwelling catheter until 10/29/24, or a period of 359 days.<br><br>A physician's order for providing indwelling catheter care every shift was discontinued on 11/05/23, and there was no evidence that Resident CR12 had an active physician's order for indwelling catheter care every shift until 10/29/24, or a period of 359 days.<br><br>A physician's order for changing an indwelling catheter every evening shift, every 30 days was discontinued on 11/05/23, and there was no evidence that Resident CR12 had an active physician's order to change the indwelling catheter until 10/29/24, or a period of 359 days.<br><br>Review of Resident CR12's treatment records revealed no evidence that staff provided catheter care and/or changed his/her indwelling foley catheter since 11/05/23, or a period of 359 days.<br><br>Review of recent departmental progress notes since 7/11/24, revealed five progress notes that included documentation of the presence of an indwelling catheter (9/24/24, 9/26/24, and 10/24/24).<br><br>Review of monthly physician's progress notes (8/15/24, 9/26/24, 10/29/24) revealed documentation of the presence of an indwelling catheter.<br><br>During an interview on 11/07/24, at 8:16, a.m. the Director of Nursing (DON) confirmed there was no evidence of a physician's order for an indwelling catheter, changing the indwelling catheter, providing catheter care since 11/05/23, or a period of 359 days. The DON also confirmed that Resident CR12 had an indwelling catheter in place between 11/05/23, and 10/29/24 (date of discharge), and that there should have been physician's orders for the indwelling catheter, changing the indwelling catheter, and providing catheter care.<br><br>28 Pa. Code 201.14 (a) Responsibility of Licensee<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 28 Pa. Code 201.18 (b)(1)(3) Management<br><br>28 Pa. Code 211.5 (f)(i) Medical Records<br><br>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing Services |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>42655<br><br>Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to ensure a safe environment related to smoking for three of eight residents reviewed who smoke at the facility (Residents R11, R14, and R104).<br><br>Findings include:<br><br>A facility policy entitled, Smoking Policy, dated 12/26/23, revealed for those Manors that permit smoking the purpose is to provide maximum safety to all resident at all times. It is the intent of the Manor to provide an environment to all those residents, who wish to smoke, the opportunity to do so in a safe environment, with optimal safety to themselves, other residents, volunteers, visitors, and staff members. Residents will be informed of the written smoking policy prior to admission. Smoking will be allowed in designated areas only. Residents must be accompanied by staff, family, or properly trained volunteers while smoking. Smoking materials will be kept in a designated area accessible only by staff. This includes the safekeeping of electronic cigarettes. Staff members are strictly prohibited from furnishing their personal smoking materials to residents. Residents electing to smoke must provide their own smoking materials.<br><br>Observations on all days on 11/04/24, 11/05/24, 11/06/24, and 11/07/24 throughout each day by all four surveyors revealed Resident R11, Resident R14, and Resident R104 smoking outside on the front patio entrance to facility.<br><br>An interview with the Nursing Home Administrator (NHA) on 11/07/24, at 11:30 a.m. confirmed that Residents R11, R14, and R104 smoke outside on the front patio entrance to the facility, which is an unauthorized smoking area and against facility policy. The NHA further confirmed that these residents often refuse to adhere to the facility smoking policy and have access to their own lighters and cigarettes creating a safety hazard and unsafe environment.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee<br><br>28 Pa. Code 201.18(b)(1) Management<br><br>28 Pa. Code 201.18(e)(1) Management<br><br>28 Pa. Code 209.3(a) Smoking |

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| | 395489 | A. Building<br>B. Wing | 11/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Corry Manor | 640 Worth Street<br>Corry, PA 16407 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496<br><br>Based on review of clinical records, observations, and staff interview, it was determined that the facility failed to provide appropriate urinary catheter (tubing inserted into the bladder to drain urine into a bag) care for one of two residents reviewed for catheters (Resident R44).<br><br>Findings include:<br><br>Review of Resident R44's clinical record revealed an admitted [DATE], with diagnoses that included Obstructive and Reflux Uropathy (disorder where urine cannot flow through the urinary tract due to an obstruction and backs up into the kidneys), Retention of Urine (a condition where the bladder doesn't empty completely when urinating), Urinary Tract Infection (an infection in any part of the urinary tract), and Overactive Bladder (a bladder control problem leading to a sudden urge to urinate).<br><br>Review of Resident R44's clinical record revealed a physician's order dated 9/11/23, for an indwelling catheter.<br><br>Observations on 11/05/24, at 11:30 a.m. revealed Resident R44 lying in bed with his/her urinary drainage bag lying on the floor with the valve (a device that allows you to empty the urinary drainage bag) of the drainage bag touching the floor.<br><br>During an interview and observations on 11/05/24, at 11:41 a.m. the Director of Nursing (DON) confirmed that Resident R44's urinary drainage bag was lying on the floor with the valve of the drainage bag touching the floor. He/she also confirmed that the urinary drainage bag should not be on the floor.<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing Services |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832<br><br>Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure that a resident's physician thoroughly documented a review of the resident's current condition, progress, and problems in maintaining or improving their physical, mental and psychosocial well-being and decisions about the continued appropriateness of the resident's current medical regimen for one (Closed Record Resident CR12) of 25 residents reviewed.<br><br>Findings include:<br><br>A facility policy entitled, Physician Services dated 12/22/23, indicated:<br><br>1. The resident's total plan of care (including medications and treatments) must be reviewed with each scheduled visit.<br><br>2. A progress note must be written, signed, and dated for each physician visit and that each progress note must contain.<br><br>- An evaluation of the resident's condition, treatment, and a review of the continued appropriateness of the resident's current medical regimen.<br><br>- Continuity of care in maintaining or improving a resident's condition and current medical regimen.<br><br>- The resident's progress or problems in maintaining or improving his/her mental and physical functioning status.<br><br>- Identification of the primary risk factors and causal factors contributing to clinical conditions, functional decline, deterioration, or potential for, and lack of improvement and whether those conditions or decline are avoidable.<br><br>- Clinical validation of the need for medical interventions or justification for decisions regarding care.<br><br>Resident CR12's clinical record revealed an admitted [DATE], with diagnoses that included stroke, hydronephrosis (condition where the kidneys swell and stretch due to a buildup of urine), epilepsy (chronic brain disorder that causes seizures, which are episodes of abnormal electrical activity in the brain), and hemorrhagic cystitis (urinary bladder lining becomes inflamed and bleeds diagnosed [DATE]).<br><br>Review of Resident CR12's diagnostic labs revealed on 9/24/24, his/her hemoglobin A1C (blood test that measures a person's average blood sugar levels over the past two to three months) was 6.5, and the next most recent labs located in Closed Record Resident CR12's clinical record were on 11/20/23, his/her Dilantin (medication to treat seizures) level was 11.1, and on 10/02/23, his/her hemoglobin A1C was 6.3, and the Dilantin level was 15.6.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident CR12's clinical record revealed physician progress notes which included the following:<br><br>10/29/24, Complicated year for patient in and out of hospital for abdominal distention, gi bleed, covid earlier in year, known diabetes, chronic dvt and seizure dx., old cva, left sided weakness, labs reviewed a1c 6.3, cbc good mildly low plts, cmp good, Dilantin level good 15, chol good. Exam clear adb distention gas, chest cta, no wheeze or rhonchi, cv regular a/p as above plus bowel issues on bowel regime family aware tough situation continue close assessment. Much better recently out in wheelchair enjoying the sunny weather belly soft far less distended, will continue current regimen, seems improved, less gassy and distention, more upbeat, chronic edema of leg, sp cva years back, overall this visit leg swelling, cough congestion, and abdominal distention seem pretty good. Overall doing ok a1c much improved 6-7 range, early visit due to vacation next 2 weeks, no concerns from staff f/u sept visit with mar check and labs for a1c, Dilantin, etc, monthly catheter changes due to chronic foley. Dilantin level 21, borderline high but no seizures. No lethargy, leg swelling, still interactive and joking today, sugars good, flu shot upcoming, change foley monthly.<br><br>9/26/24, Complicated year for patient in and out of hospital for abdominal distention, gi bleed, covid earlier in year, known diabetes, chronic dvt and seizure dx., old cva, left sided weakness, abs reviewed a1c 6.3, cbc good mildly low plts, cmp good, Dilantin level good 15, chol good. Exam clear adb distention gas, chest cta, no wheeze or rhonchi, cv regular a/p as above plus bowel issues on bowel regime family aware tough situation continue close assessment. Much better recently out in wheelchair enjoying the sunny weather belly soft far less distended, will continue current regimen, seems improved, less gassy and distention, more upbeat, chronic edema of leg, sp cva years back, overall this visit leg swelling, cough congestion, and abdominal distention seem pretty good. Overall doing ok a1c much improved 6-7 range, early visit due to vacation next 2 weeks, no concerns from staff, f/u sept visit with mar check and labs for a1c, Dilantin, etc, monthly catheter changes due to chronic foley. Dilantin and a1c upcoming. Mar reviewed. Joking more.<br><br>8/15/24, Complicated year for patient in and out of hospital for abdominal distention, gi bleed, covid earlier in year, known diabetes, chronic dvt and seizure dx., old cva, left sided weakness, abs reviewed a1c 6.3, cbc good mildly low plts, cmp good, Dilantin level good 15, chol good. Exam clear adb distention gas, chest cta, no wheeze or rhonchi, cv regular a/p as above plus bowel issues on bowel regime family aware tough situation continue close assessment. Much better recently out in wheelchair enjoying the sunny weather belly soft far less distended, will continue current regimen, seems improved, less gassy and distention, more upbeat, chronic edema of leg, sp cva years back, overall this visit leg swelling, cough congestion, and abdominal distention seem pretty good. Overall doing ok a1c much improved 6-7 range, early visit due to vacation next 2 weeks, no concerns from staff f/u sept visit with mar check and labs for a1c, Dilantin, etc, monthly catheter changes due to chronic foley.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 7/25/24, Complicated year for patient in and out of hospital for abdominal distention, gi bleed, covid earlier in year, known diabetes, chronic dvt and seizure dx., old cva, left sided weakness, abs reviewed a1c 6.3, cbc good mildly low plts, cmp good, Dilantin level good 15, chol good. Exam clear adb distention gas, chest cta, no wheeze or rhonchi, cv regular a/p as above plus bowel issues on bowel regime family aware tough situation continue close assessment. Much better recently out in wheelchair enjoying the sunny weather belly soft far less distended, will continue current regimen, seems improved, less gassy and distention, more upbeat, chronic edema of leg, sp cva years back, overall this visit leg swelling, cough congestion, and abdominal distention seem pretty good. Overall doing ok a1c much improved 6-7 range, update this visit very little changed encouraged to get out more but keeps to room, leg chronic edema and sore.<br><br>6/27/24, Complicated year for patient in and out of hospital for abdominal distention, gi bleed, covid earlier in year, known diabetes, chronic dvt and seizure dx., old cva, left sided weakness, abs reviewed a1c 6.3, cbc good mildly low plts, cmp good, Dilantin level good 15, chol good. Exam clear adb distention gas, chest cta, no wheeze or rhonchi, cv regular a/p as above plus bowel issues on bowel regime family aware tough situation continue close assessment. Much better recently out in wheelchair enjoying the sunny weather belly soft far less distended, will continue current regimen, seems improved, less gassy and distention, more upbeat, chronic edema of leg, sp cva years back, overall this visit leg swelling, cough congestion, and abdominal distention seem pretty good. Overall doing ok a1c much improved 6-7 range, color good more interactive.<br><br>5/30/24, Complicated year for patient in and out of hospital for abdominal distention, gi bleed, covid earlier in year, known diabetes, chronic dvt and seizure dx., old cva, left sided weakness, abs reviewed a1c 6.3, cbc good mildly low plts, cmp good, Dilantin level good 15, chol good. Exam clear adb distention gas, chest cta, no wheeze or rhonchi, cv regular a/p as above plus bowel issues on bowel regime family aware tough situation continue close assessment. Much better recently out in wheelchair enjoying the sunny weather belly soft far less distended, will continue current regimen, seems improved, less gassy and distention, more upbeat, chronic edema of leg, sp cva years back, overall this visit leg swelling, cough congestion, and abdominal distention seem pretty good. Overall doing ok a1c much improved 6-7.<br><br>4/25/24, Complicated year for patient in and out of hospital for abdominal distention, gi bleed, covid earlier in year, known diabetes, chronic dvt and seizure dx., old cva, left sided weakness, abs reviewed a1c 6.3, cbc good mildly low plts, cmp good, Dilantin level good 15, chol good. Exam clear adb distention gas, chest cta, no wheeze or rhonchi, cv regular a/p as above plus bowel issues on bowel regime family aware tough situation continue close assessment. Much better recently out in wheelchair enjoying the sunny weather belly soft far less distended, will continue current regimen, seems improved, less gassy and distention, more upbeat, chronic edema of leg, sp cva years back, overall this visit leg swelling, cough congestion, and abdominal distention seem pretty good.<br><br>3/27/24, Complicated year for patient in and out of hospital for abdominal distention, gi bleed, covid earlier in year, known diabetes, chronic dvt and seizure dx., old cva, left sided weakness, abs reviewed a1c 6.3, cbc good mildly low plts, cmp good, Dilantin level good 15, chol good. Exam clear adb distention gas, chest cta, no wheeze or rhonchi, cv regular a/p as above plus bowel issues on bowel regime family aware tough situation continue close assessment. Much better recently out in wheelchair enjoying the sunny weather belly soft far less distended, will continue current regimen, seems improved, less gassy and distention, more upbeat, chronic edema of leg, sp cva years back.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2/28/24, Complicated year for patient in and out of hospital for abdominal distention, gi bleed, covid earlier in year, known diabetes, chronic dvt and seizure dx., old cva, left sided weakness, abs reviewed a1c 6.3, cbc good mildly low plts, cmp good, Dilantin level good 15, chol good. Exam clear adb distention gas, chest cta, no wheeze or rhonchi, cv regular a/p as above plus bowel issues on bowel regime family aware tough situation continue close assessment. Much better recently out in wheelchair enjoying the sunny weather belly soft far less distended, will continue current regimen.<br><br>1/24/24, Complicated year for patient in and out of hospital for abdominal distention, gi bleed, covid earlier in year, known diabetes, chronic dvt and seizure dx., old cva, left sided weakness, abs reviewed a1c 6.3, cbc good mildly low plts, cmp good, Dilantin level good 15, chol good. Exam clear adb distention gas, chest cta, no wheeze or rhonchi, cv regular a/p as above plus bowel issues on bowel regime family aware tough situation continue close assessment. Bowels still off and on, distended today but moving gas and appetite ok, watch closely, family aware, spoke to son recently.<br><br>12/22/23, Complicated year for patient in and out of hospital for abdominal distention, gi bleed, covid earlier in year, known diabetes, chronic dvt and seizure dx., old cva, left sided weakness, abs reviewed a1c 6.3, cbc good mildly low plts, cmp good, Dilantin level good 15, chol good. Exam clear adb distention gas, chest cta, no wheeze or rhonchi, cv regular a/p as above plus bowel issues on bowel regime family aware tough situation continue close assessment.<br><br>During an interview on 11/07/24, at 10:45 a.m. the Nursing Home Administrator confirmed that the above listed physician progress notes did not accurately reflect Resident CR12's current health condition at the time of the physician's visit, that Resident CR12 was last COVID positive on 11/20/22, and that the hemoglobin A1C and Dilantin levels were not reflective of the resident's most recent values prior to the physician visits.<br><br>28 Pa. Code 201.14(a) Responsibility of Licensee<br><br>28 Pa. Code 201.18(b)(1)(3) Management<br><br>28 Pa. Code 211.2(d)(3) Medical Director<br><br>28 Pa. Code 211.5(f)(ii)(ix) Medical records |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496<br><br>Based on review of clinical records, and staff interviews, it was determined that the facility failed to provide a clinical rationale and duration for the continued use of a PRN (as needed) psychotropic (affecting the mind) medication beyond 14 days for one of five residents reviewed for psychotropic medications (Resident R75).<br><br>Findings include:<br><br>Resident R75's clinical record revealed an admitted [DATE], with diagnoses that included Alzheimer's Disease (brain disorder that slowly destroys memory, thinking skills, and, over time the ability to carry out the simplest tasks), Restlessness and Agitation (an inability to rest or relax because of anxiety), and Hyperlipidemia (high cholesterol).<br><br>Review of Resident R75's medication orders revealed a physician's order dated 6/29/24, to administer Hydroxyzine (anti-anxiety) 25 milligrams (mg) Intramuscularly (an injection that goes into the muscle) every eight hours as needed for restlessness/agitation. Further review of physician's orders revealed an order dated 6/29/24, to administer Lorazepam (anti-anxiety) one mg Intramuscularly every six hours as needed for restlessness/agitation if Hydroxyzine ineffective.<br><br>Resident R75's medication orders lacked the required stop date within 14 days or a clinical rationale for continuing beyond 14 day for Hydrozyzine and Lorazepam.<br><br>During an interview on 11/06//24, at 1:05 p.m. the Director of Nursing (DON) confirmed that Resident R75's Hydroxyzine and Lorazepam orders lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days. He/she also confirmed that the medication should have a clinical rationale or duration to continue beyond 14 days.<br><br>28 Pa. Code 211.5(f)(i) Medical records<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655<br><br>Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to label a multi-dose insulin (medication to treat elevated blood sugar levels) pen with the date it was opened, and discard an expired multi-dose insulin pen in one of four medication carts (Unit C), and failed to properly store medications for use for one of 25 residents reviewed (Resident R37).<br><br>Findings include:<br><br>Review of the facility policy entitled Medication Storage in the Facility dated [DATE], indicated medications and biologicals are to be stored safely, securely, and properly following manufacturerer's recommendations or those of the supplier. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures should immediately be removed from stock, returned to ICP, and reordered from the pharmacy, if a current order exists.<br><br>Observation on [DATE], at 3:20 p.m. revealed the Unit C medication cart contained two opened undated multi-dose Lantus insulin pens and the manufacturer's packaging was labeled to discard within 28 days of opening. The medication cart also contained a multi-dose Humalog insulin pen with an opened date of [DATE], which was 10 days past expiration, and the manufacturer's packaging was labeled to discard within 28 days of opening.<br><br>During an interview at that time, LPN Employee E2 confirmed that multi-dose vials/containers of medication are to be dated upon opening to ensure that staff discard them in a timely manner and the medication is not to be utilized past the medication expiration.<br><br>Review of the facility policy entitled Self-Administration of Medications by Resident dated [DATE], indicated Bedside storage of medication is allowed only upon the specific order of the resident's physician. And The Director of Nursing services is responsible for instructing all licensed and non-licensed nursing personal that drugs discovered at bedside are to be reported to the charge nurse on duty for removal .<br><br>Review of Resident R37's clinical record revealed an admitted [DATE], with diagnoses that included Diabetes (a health condition that caused by the body's inability to produce enough insulin), Anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and Hypertension (high blood pressure). Resident R37's clinical record lacked evidence of a physician's order for medications stored at bedside.<br><br>Observation on [DATE], at 1:15 p.m. revealed an open half empty bottle of Robitussin Congestant sitting on Resident R37's tray table.<br><br>During an interview on [DATE], at 1:26 p.m. Licensed Practical Nurse (LPN) Employee E2 confirmed that an open half empty bottle of Robitussin Congestant was sitting on Resident R37's tray table. He/she also confirmed that the bottle of Robitussin Congestant should not be in Resident R37's room.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on [DATE], at 1:30 p.m. the Director of Nursing confirmed that there was no evidence of a physician order for medication to be left at Resident R 37's bedside or a self-administration of medication evaluation. He/she also confirmed that medication should not be kept at bedside without a physician order and a self-administration of medications evaluation.<br><br>28 Pa. Code 201.18(b)(1) Management<br><br>28 Pa. Code 211.9(a)(1) Pharmacy services<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>48496<br><br>Based on observations, review of facility records, and resident and staff interviews, it was determined that the facility failed to provide sufficient staff with appropriate competencies to carry out the functions of the food and nutrition services in the kitchen.<br><br>Findings include:<br><br>Review of facility policy entitled Tray Service dated 12/26/23, revealed Procedure Hot and cold foods are attractively assembled on trays for resident. Responsible Cooks, Nutrition Services workers.<br><br>Review of Job Description for Nutrition Services Assistant revealed Position Responsibilities Must meet job related competencies . and Knowledge, Skills and Abilities: .Serve-safe certification is preferred.<br><br>Review of HCF SNF On The Job Training Program Trainee Packet Nutrition Services revealed Training Schedule: New staff member will work the schedule of their coach for the first five days. The initial three days will be hands-on with the coach and Trainee.<br><br>Review of four weeks of dietary schedule revealed that there are four positions on the day shift and four positions on the evening shift. Review of the four week schedule lacked evidence that the appropriate number of trained dietary staff were scheduled each day.<br><br>Observations of tray line on 11/04/24, at 11:15 a.m. revealed one of three dietary staff left the dietary department with an open food cart without lids covering the milk and juice on three different occasions. Further observations revealed dietary staff waiting approximately 10 minutes between each of the three food carts to continue with tray line until the staff member returned.<br><br>Resident R37 indicated during an interview on 11/04/24, at 1:00 p.m. that his/her breakfast meal is always the same cold eggs. He/she also indicated that the dietary department just repeats the same menu week to week.<br><br>Resident R57 indicated during an interview on 11/05/24, at 10:15 a.m. that the food is awful there is no flavor and it's not always hot. He/she also indicated that residents get the same thing over and over.<br><br>Resident R72 indicated during an interview on 11/04/24, at 2:20 p.m. that his/her meals are always a surprise when you open the lid. He/she further indicated the dietary staff do not follow the menu, and he/she buys food from<br><br>Wal-Mart to eat instead, due to meals are not good and he/she is tired of them being a surprise.<br><br>Resident R33 indicated during an interview on 11/05/24, at 9:30 a.m. that there are not enough staff to get food out to keep it warm and food is not good.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395489 | A. Building<br>B. Wing | 11/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Corry Manor | 640 Worth Street<br>Corry, PA 16407 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with Resident R91's family member on 11/07/24, at 9:30 a.m. he/she indicated there were several additional staff in the dining room to assist residents with their meals during the survey (11/04/24, 11/05/24, and 11/06/24) when family visited the facility. He/she further indicated that it is unfair that the facility can have these staff members assist when surveyors are watching during the survey process, but when the survey is not going on, the residents have to wait and receive cold, unappealing food. He/she further indicated that the family brings in food due to sometimes food is unavailable and their loved one is at risk for weight loss.<br><br>During a Resident Council meeting residents indicated that the food is repetitive, food is prepackaged because there is not enough staff in the dietary department.<br><br>During an interview on 11/04/24, at 11:30 a.m. with [NAME] Employee E3 he/she revealed that the facility is using a low staffing menu because of the dietary staffing shortage. He/she stated that the menu is a weekly menu, and it just rotates weekly. He/she revealed that the dietary department does not cook meals and the facility gets prepackaged food that just needs heated through due to staffing in the dietary department. He/she also revealed that other departments have worked in the dietary department that are not trained.<br><br>During an interview on 11/07/24, at 9:45 a.m. Dietary [NAME] Employee E8 revealed that staffing in the dietary department is four staff on dayshift and four staff on evening shift. He/she revealed that the dietary department is using a low staff menu that just repeats every week. He/she also indicated that there are days when he/she comes to work that he/she is the only staff in the dietary department.<br><br>During an interview on 11/07/24, at 12:50 p.m. the Director of Nursing indicated that some of the staff listed on the dietary time sheets were staff from Nursing, Housekeeping and Administrative departments and had worked in the dietary department.<br><br>During an interview on 11/07/24, at 1:05 p.m. the Dietary Manager confirmed that there is a staffing shortage in the dietary department, there are shifts that are not covered on the schedule and that other department staff have worked in the dietary department without appropriate competencies. He/she also confirmed that staff working in the dietary department need the appropriate competencies to carry out dietary duties.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee<br><br>28 Pa. Code 201.18(b)(3) Management |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496<br><br>Based on review of facility policies, observations, and staff interview, it was determined that the facility failed to ensure that food was stored in accordance with standards for food safety in one of one walk-in coolers, failed to label food brought into the facility with the resident's name and date it was opened in one of one pantry and failed to utilize hair nets to prevent contamination in the kitchen.<br><br>Findings include:<br><br>Review of facility policy entitled Storage of Perishable Foods dated [DATE], revealed Many perishable food items may be served until the manufacturer's use by date.<br><br>Review of facility policy entitled Food Brought by Family/Visitors dated [DATE], revealed All foods requiring refrigeration must be dated and labeled with the resident's name . Perishable items may be stored for no greater than 3 days.<br><br>Review of policy entitled Dress Code dated [DATE], revealed Purpose: To present a well-groomed appearance . to provide a standard of sanitation in dress. b. Hair net, beard if facial hair present.<br><br>Observations of the kitchen on [DATE], at 10:40 a.m. revealed an open partially used container of sour cream in the cooler with an open date of [DATE], and an expiration date of [DATE], and a container of potato salad with a best buy date of [DATE].<br><br>During an interview with the Dietary [NAME] Employee E3 on [DATE], during the time of observations he/she confirmed that the open container of sour cream and the container of potato salad were beyond their expiration date. He/she also confirmed that the items should have been discarded by their expiration date.<br><br>Observation of the resident pantry refrigerator/freezer on [DATE], at 1:35 p.m. revealed in the freezer a frozen bag of green beans and a frozen bag of tortellini without a resident name. In the refrigerator was an open bottle of ranch salad dressing without a resident name and an expiration date of [DATE].<br><br>During an interview on [DATE], with Licensed Practical Nurse (LPN) Employee E4 during the time of observations he/she confirmed that the frozen bag of green beans and the frozen bag of tortellini were absent of resident names, and the open bottle of ranch salad dressing was absent of a resident name and was also beyond its expiration date. He/she also confirmed that the items should have resident names written on them and that the expired ranch salad dressing should have been discarded.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During observations of tray line on [DATE], at 11:15 a.m. two staff entered the kitchen without hair nets covering their hair, one staff member was standing next to the juice dispenser and the other staff member was standing approximately two feet away from the steam table. Further observation during tray line, revealed three open food carts left the kitchen, two carts went to D Wing, and one went to C Wing containing glasses of milk and juice without lids covering the milk and juice being exposed during transport to the units.<br><br>During an interview with the Dietary [NAME] Employee E3 on [DATE], during the time of observations, he/she confirmed that staff entered the kitchen without hair nets on and that three open food carts left the kitchen without lids on the glasses of milk and juice. He/she also confirmed that all staff are required to have hair nets on when in the kitchen and the glasses of milk and juice should have been covered before leaving the kitchen.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee<br><br>28 Pa. Code 201.18(b)(1)(3) Management<br><br>28 Pa. Code 211.6(f) Dietary services |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655<br><br>Based on review of clinical records, observations, and staff interview, it was determined that the facility failed to use appropriate infection control practices for disinfection and storage of a graduate (measuring device) for one of 25 residents reviewed (Resident R6).<br><br>Findings include:<br><br>No facility policy provided.<br><br>Resident R6's clinical record revealed an admitted [DATE], with diagnoses that included atrial fibrillation (an irregular, often rapid rate that causes poor blood flow starting in the atria chamber of the heart), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), gastrostomy (a surgical procedure that creates an opening in the abdomen that allows a feeding tube to be inserted directly into the stomach), neuromuscular dysfunction of the bladder (a condition in people who lack bladder control due to a brain, spinal cord or nerve problem).<br><br>Observations on 11/04/24, at 1:30 p.m. revealed a graduate sitting on Resident R6's bedside table with Tube 9/6/24 2100 written on it.<br><br>During an interview on 11/04/24, at 1:40 p.m. Registered Nurse (RN) Employee E5 confirmed that the graduate should have been discarded related to infection control risks of keeping it at bedside since 9/06/24, and was unaware if the graduate has been safely sanitized. RN Employee E5 further confirmed that he/she does not know what the graduate is utilized for, due to Resident R6 has a urinary catheter bag that is emptied with a graduate, and a gastrostomy tube for his/her nutrition that a graduate is typically not utilized for.<br><br>28 Pa. Code 211.12 (d)(1)(5) Nursing services |