STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Manor	435 North Broad Street Grove City, PA 16127

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655 Based on review of facility policies and clinical records and staff interviews, it was determined that the facility failed to ensure that residents were free of neglect during care, which resulted in actual harm of Stage Three (full-thickness skin and tissue loss) pressure ulcer development of the coccyx (small triangular bone at the base of the spinal column), buttocks, and heel for two of two closed records reviewed for pressure areas (Residents CR1 and Resident CR2). Findings include: Review of a facility policy entitled Identifying Resident Neglect dated 7/22/24, revealed 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 physical 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 and this has resulted in (or may result in) physical harm, pain mental anguish or emotional distress. Review of a facility policy entitled Prevention of Pressure Ulcer/Injury dated 7/22/24, revealed the facility would Assess the resident on admission (within eight hours) for existing pressure/injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. Conduct a comprehensive skin assessment upon admission, including: Skin integrity - any evidence of existing or developing pressure ulcers or injuries; Tissue tolerance - the ability of the skin (and supporting structures) to endure the effects of pressure; and Areas of impaired circulation due to pressure from positioning or medical devices. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. Identify any signs of developing pressure injuries (i.e. nonblanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.); Wash the skin after any episodes of incontinence, using pH balanced skin cleanser; Moisturize dry skin daily; and Reposition resident as indicated on the care plan. Resident CR1's clinical record revealed an admitted [DATE], and discharge date of [DATE], with diagnoses that included partial intestinal obstruction (a gastrointestinal condition in which digested material is prevented from passing normally through the bowel), muscle weakness, unsteadiness on feet, and need for assistance with personal care. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Grove Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 435 North Broad Street Grove City, PA 16127	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	An Admission / Readmission Nursing Evaluation completed on 5/08/24, at 4:31 p.m. revealed Resident CR1's skin color was warm and unremarkable upon assessment with a pressure area noted as 0.02 cm [centimeter] x 0.02 cm skin tear type - Stage Two (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough) - to right buttocks. A Braden Scale (assessment used to assist in identifying risk of developing a pressure ulcer) was completed as part of the admission assessment on 5/08/24, at 4:32 p.m. which revealed a total score of 14, indicating Resident CR1 was at a moderate risk for developing pressure ulcers. The assessment further indicated Resident CR1 was at moderate risk for developing pressure ulcers due to very limited sensory perception (ability to feel or communicate discomfort), incontinence, limited physical activity - spends majority of shift in bed or chair, makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently, poor nutrition, and risk for friction and shear (sliding on sheet causing skin irritation). A Bowel and Bladder Screener dated 5/14/24, revealed Resident CR1 was occasionally incontinent of bowel and bladder, a two person assist, and condition of the skin on genital, perineal, buttocks had non-blanchable redness or small open area. Resident CR1's care plan dated 5/08/24, revealed pressure/skin impairments as focus with interventions as weekly skin assessments to be performed during regularly scheduled bath/shower per facility policy. Follow facility policies/protocol for the prevention of skin breakdown. Notify nurse immediately of any new areas of skin breakdown, redness, bruises, discoloration noted during bath or daily care. Resident CR1's Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), with an Assessment Reference Date (ARD) of 5/14/24, section GG0170A entitled Mobility (roll left and right: The ability to roll from lying on back to left and right side, and return to lying on the bed) was coded as requiring substantial/maximal assistance of staff to complete task. Section M0100A entitled Determination of Pressure Ulcer Injury Risk - Resident has a pressure ulcer / injury was coded as Yes. Section M0300B1 entitled Number of Stage 2 pressure ulcers was coded 1 and Section M0300C1 entitled Number of Stage 3 pressure ulcers was coded 0. Section M0150 entitled Risk of Pressure Ulcer / Injuries - Is this Resident at risk for developing pressure ulcers/injuries was coded as Yes. Section M1200C entitled Skin and Ulcer/Injury Treatments - Turning and Repositioning program was coded as No. Resident CR1's MDS, with an ARD of 6/24/24, Section M0100A entitled Determination of Pressure Ulcer Injury Risk - Resident has a pressure ulcer / injury was coded as Yes. Section M0300B1 entitled Number of Stage 2 pressure ulcers was coded 0, Section M0300C1 entitled Number of Stage 3 pressure ulcers was coded 1, and Section M0300F1 entitled Number of unstageable pressure ulcers due to coverage of wound bed by slough (dead tissue within a wound, often appearing as yellow, tan, or white material) and/or eschar (dry, dead tissue within a wound) was coded 1. Section M0150 entitled Risk of Pressure Ulcer / Injuries - Is this Resident at risk for developing pressure ulcers/injuries was coded as Yes. Section M1200C entitled Skin and Ulcer/Injury Treatments - Turning and Repositioning program was coded as No. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Grove Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 435 North Broad Street Grove City, PA 16127	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident CR1's physician orders revealed an order dated 5/07/24, for weekly skin assessments to be completed every dayshift every Tuesday. A physician order dated 5/07/24, was noted with a discontinue date of 5/09/24, for house ointment/cream after each incontinent episode for prevention and protection every shift for treatment. A physician order dated 6/14/24, revealed Doxycycline Hyclate 100 milligrams two times a day for right gluteus wound for 10 Days. Resident CR1's progress notes dated 5/10/24, revealed Area to right buttocks reassessed and noted to be 2. 5 cm x 2.0 cm x 0.2 cm. It is currently a Stage 2 pressure injury. Per her daughter, she has a history of a pressure injury to this location that never completely healed. Area covered with a foam dressing. Further progress notes for Resident CR1 dated 5/24/24, by a Wound Certified Registered Nurse Practitioner (CRNP) indicated resident was seen for wound to the right gluteus (buttocks) noted by staff on admission assessment. Wound: 1 Location: right gluteus Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: New Size: 3 cm x 2 cm x 0 cm Wound Base: 0% epithelial, 30 granulation, 70 slough, 0% eschar. Exudate: Moderate amount of Serous. Treatment: Cleanse with 0.125% Dakins solution, apply Medical grade honey. Calcium Alginate, Zinc Oxide to base of wound, secure with Bordered gauze, change daily and PRN (as needed). Continue: offloading pressure on area, side to side turning/repositioning (q 2 hrs), pressure redistribution, keep heels elevated. Further progress notes for Resident CR1 dated 5/31/24, by CRNP revealed wound/skin condition noted Wound Assessment Wound 1 Location: right gluteus Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: Worsening Size: 4 cm x 4 cm x 0.5 cm Wound Base: 0% epithelial, 30 granulation, 70 slough, 0% eschar. Exudate: Moderate amount of Serous. Treatment: Cleanse with 0.125% Dakins solution, apply Calcium alginate, Zinc Oxide Paste, SANTYL (NICKEL THICKNESS) to base of wound, secure with Bordered Gauze, change Daily, and PRN. Wound: 2 Location: left heel Primary Etiology: Pressure State/Severity: Stage 3 Wound Status: New Size 2 cm x 1.5 cm x 0 cm Wound Base 0 % epithelial, open dark red/purple nonblanching tissue granulation, 0% slough, 0% eschar. Surgical Wound Debridement with Treatment: Cleanse with normal saline, apply Medical grade honey, Calcium alginate, Zinc Oxide Paste to base of the wound, secure with Bordered gauze, change Daily, and PRN. Further progress notes for Resident CR1 dated 6/21/24, by CRNP revealed Right gluteal wound reclassified due to decline. Wound: 1 right gluteus Primary Etiology: Pressure Stage/Severity: Unstageable Wound Status: Worsening Size 6 cm x 6 cm x 0.5 cm Wound Base: 0% epithelial, 0% granulation, 100% slough, 0% eschar. Exudate: Moderate amount of Serous. Surgical Wound Debridement with Treatment: Cleanse with 0. 125% Dakins solution, apply Zinc Oxide Paste, SANTYL (NICKEL THICKNESS), Dakins moistened fluffed gauze to base of the wound, secure with Bordered gauze, change Daily, and PRN. Wound: 2 left heel Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: improving with delayed wound closure Size 1.5 cm x 2.5 cm x 0.3 cm Wound Base: 0% epithelial, 100% granulation, 0% slough, 0% eschar. Exudate: Moderate amount of Serous. Treatment: Cleanse with 0.125% Dakins solution, apply Zinc Oxide Paste, Collagen, Silver Alginate to base of the wound, secure with ABD, Rolled gauze, change Daily and PRN. Resident CR1's clinical record lacked evidence that an assessment of the right buttocks was completed by a RN from 5/10/24, to 5/24/24, the time the Stage Two pressure ulcer worsened to a Stage Three pressure ulcer. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Grove Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 435 North Broad Street Grove City, PA 16127	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident CR1's clinical record lacked evidence of turning/repositioning, including recommendations from the Wound CRNP dated 5/24/24, for offloading pressure on area, side to side turning/reposition (q2 hrs), pressure redistribution, keep heels elevated. Resident CR1's clinical record lacked evidence that the physician ordered weekly skin assessments were completed from 5/14/24, to the day of discharge 6/24/24. The Stage Two pressure ulcer of the right buttocks worsened to a Stage Three pressure ulcer, and a new Stage Three pressure ulcer was discovered to the left heel during the period elapsed from 5/08/24, to 6/24/24. The Director of Nursing (DON) confirmed lack of skin assessments for Resident CR1 during an interview at 2:26 p.m. on 8/16/24. The Nursing Home Administrator (NHA) confirmed on 8/22/24, at 3:50 p.m. the facility failed to provide skin assessments, interventions in place and monitoring for skin integrity, to prevent the development and/or worsening of pressure ulcers. The facility failed to ensure that Resident CR1 was free from neglect which resulted in actual harm of a Stage Three pressure ulcer wound to right buttocks and Stage Three pressure ulcer wound to left heel. Resident CR2's clinical record revealed an admitted [DATE], and discharge date of [DATE], with diagnoses that included cellulitis (bacterial skin infection) of left leg, diverticulitis (an inflammation of infection in one or more small pouches in the digestive tract), non-pressure chronic ulcer (a long-lasting open sore typically caused by poor circulation), and obesity. An Admission / Readmission Nursing Evaluation completed on 7/18/24, at 1:31 p.m. indicated Resident CR2's skin color was warm and unremarkable upon assessment with no pressure areas or evidence of pressure areas. A Braden Scale was completed as part of the admission assessment on 7/18/24, at 2:07 p.m. revealed /a total score of 16, indicating Resident CR2 was at a low risk for developing pressure ulcers. The assessment further indicated Resident CR2 was at low risk for developing pressure ulcers due to slightly limited sensory perception, incontinence, limited physical activity - spends majority of shift in bed or chair, makes frequent though slight changes in body or extremity position independently, adequate nutrition, and risk for friction and shear (sliding on sheet causing skin irritation). A Bowel and Bladder Screener dated 7/23/24, revealed Resident CR2 was continent of bowel and bladder, a one-person assist, and no redness to the skin on genital, perineal, buttocks. Resident CR2's care plan dated 5/08/24, revealed potential pressure ulcer development as focus with interventions as weekly skin assessments to be performed during regularly scheduled bath/shower per facility policy. Notify nurse immediatel of any new areas of skin breakdown, redness, bruises, discoloration noted during bath or daily care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident CR2's MDS, with an ARD of 7/24/24, section GG0170A entitled Mobility (roll left and right: The ability to roll from lying on back to left and right side, and return to lying on the bed) was coded as requiring partial/moderate assistance of staff to complete task. Section M0100A entitled Determination of Pressure Ulcer Injury Risk - Resident has a pressure ulcer / injury was coded as No. Section M0150 entitled Risk of Pressure Ulcer / Injuries - Is this Resident at risk for developing pressure ulcers/injuries was coded as Yes. Section M1200A entitled Skin and Ulcer/Injury Treatments - Pressure reducing device for chair was coded as No, and Section M1200C entitled Skin and Ulcer/Injury Treatments - Turning and Repositioning program was coded as No. Resident CR2's physician orders revealed an order dated 7/18/24, for weekly skin assessments to be completed every dayshift every Thursday. On 7/19/24, Wound CRNP recommendations stated, continue pressure redistribution support surface, continue Foam wheelchair cushion to wheelchair, limit sitting time to 2 hours per episode, Continue: offloading pressure on area, side to side turning/repositioning (q 2 hrs), pressure distribution, keep heels elevated. Resident CR2's progress notes dated 8/04/24, stated Pts [patients] dtr [daughter] concerned re [regarding] pts open sores on buttocks. Did inform the dtr re wound care that was performed during the night. Dtr is concerned re pt going home with open sores. Informed dtr that will have wound care RN and NP assess pt before d/c [discharge]. Dtr. agrees. Further progress notes for Resident CR2's Wound CRNP's progress notes dated 8/09/24, stated Wounds to bilateral glutes noted to have declined on today's exam, Re-education was provided to the staff, patient regarding the patient's wound, dressing care, offloading, and general treatment recommendations. Wound: 3 Location: coccyx Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: Worsening Size: 1 cm x 1 cm 1 cm Wound Base: 100% granulation Exudate: Moderate amount of Serous. Treatment: Cleanse with 0. 125% Dakins solution, apply Medical grade honey, Calcium alginate, Zinc Oxide Paste to base of the wound, secure with Bordered gauze, change Daily, and PRN. Wound: 5 Location: left gluteus Primary Etiology: Pressure State/Severity: Stage 3 Wound Status: New Size: 1 cm x 1 cm x 1 cm Wound Base: 50% granulation, 50 % slough Exudate: Moderate amount of Serous Treatment: Cleanse with 0.125% Dakins solution, apply Medical grade honey, Calcium alginate, Zinc Oxide Paste to base of the wound, secure with Bordered gauze, change Daily, and PRN. Wound: 6 Location: right gluteus Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: New Size 1 cm x 1 cm x 0.3 cm Wound Base: 50% granulation, 50% slough Exudate: Moderate amount of Serous. Treatment: Cleanse with 0.125% Dakins solution, apply Medical grade honey, Calcium alginate, Zinc Oxide Paste to base of the wound, secure with Bordered gauze, change Daily, and PRN. Resident CR2's clinical record lacked evidence of turning/repositioning, including recommendations from Wound CRNP dated 7/19/24, to limit sitting time to 2 hours per episode and to continue offloading presure on area, side to side turning/reposition (q2 hrs), pressure redistribution, keep heels elevated. Resident CR2's clinical record lacked evidence that the physician ordered weekly skin assessments were completed from 7/18/24, to the day of discharge 8/09/24 allowing a Stage Three pressure ulcer to develop on the coccyx, right buttocks, and left buttocks within a 23 day period of time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER: Grove Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 435 North Broad Street, Grove City, PA 16127	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	The DON confirmed lack of skin assessments for Resident CR2 during an interview at 2:26 p.m. on 8/16/24. The NHA confirmed on 8/22/24, at 3:50 p.m. the facility failed to conduct skin assessments, and maintain interventions in place and monitoring for skin integrity, to prevent the development and/or worsening of pressure ulcers and skin conditions. The facility failed to ensure that Resident CR2 was free from neglect which resulted in actual harm of Stage Three pressure ulcer wounds to the coccyx, right buttocks, and left buttocks. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(2)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655 Based on review of facility policy and clinical record and staff interviews, it was determined that the facility failed to ensure that residents were monitored, adequately assessed, and preventative measures were implemented to prevent ulcers from developing or worsening, resulting in actual harm of Stage Three (full-thickness skin and tissue loss) pressure ulcer development of the coccyx (small triangular bone at the base of the spinal column), buttocks, and heel for two of two closed records reviewed for pressure ulcers (Residents CR1 and Resident CR2). Findings include: Review of a facility policy entitled Prevention of Pressure Ulcer/Injury dated 7/22/24, revealed the facility would Assess the resident on admission (within eight hours) for existing pressure/injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. Conduct a comprehensive skin assessment upon admission, including: Skin integrity - any evidence of existing or developing pressure ulcers or injuries; Tissue tolerance - the ability of the skin (and supporting structures) to endure the effects of pressure; and Areas of impaired circulation due to pressure from positioning or medical devices. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs [Activities of Daily Living]. Identify any signs of developing pressure injuries (i.e. nonblanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.); Wash the skin after any episodes of incontinence, using pH balanced skin cleanser; Moisturize dry skin daily; and Reposition resident as indicated on the care plan. Resident CR1's clinical record revealed an admitted [DATE], and discharge date of [DATE], with diagnoses that included partial intestinal obstruction (a gastrointestinal condition in which digested material is prevented from passing normally through the bowel), muscle weakness, unsteadiness on feet, and need for assistance with personal care. An Admission / Readmission Nursing Evaluation completed on 5/08/24, at 4:31 p.m. revealed that Resident CR1's skin color was warm and unremarkable upon assessment with a pressure area noted as 0.02 cm x 0. 02 cm skin tear type - stage two (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough) - to right buttocks. A Braden Scale (assessment used to assist in identifying risk of developing a pressure ulcer) was completed as part of the admission assessment on 5/08/24, at 4:32 p.m. which revealed a total score of 14, indicating Resident CR1 was at a moderate risk for developing pressure ulcers. The assessment further indicated Resident CR1 was at moderate risk for developing pressure ulcers due to very limited sensory perception (ability to feel or communicate discomfort), incontinence, limited physical activity - spends majority of shift in bed or chair, makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently, poor nutrition, and risk for friction and shear (sliding on sheet causing skin irritation). A Bowel and Bladder Screener dated 5/14/24, indicated Resident CR1 was occasionally incontinent of bowel and bladder, a two-person assist, and condition of the skin on genital, perineal (skin between genitals and anus), buttocks had non-blanchable redness or small open area. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0686

Level of Harm - Actual harm

Residents Affected - Few

Resident CR1's care plan dated 5/08/24, revealed pressure/skin impairments as focus with interventions as weekly skin assessments to be performed during regularly scheduled bath/shower per facility policy. Follow facility policies/protocol for the prevention of skin breakdown. Notify nurse immediately of any new areas of skin breakdown, redness, bruises, discoloration noted during bath or daily care.

Resident CR1's Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), with an Assessment Reference Date (ARD) of 5/14/24, section GG0170A entitled Mobility (roll left and right: The ability to roll from lying on back to left and right side, and return to lying on the bed) was coded as requiring substantial/maximal assistance of staff to complete task. Section M0100A entitled Determination of Pressure Ulcer Injury Risk - Resident has a pressure ulcer / injury was coded as Yes. Section M0300B1 entitled Number of Stage 2 pressure ulcers was coded 1 and Section M0300C1 entitled Number of Stage 3 pressure ulcers was coded 0. Section M0150 entitled Risk of Pressure Ulcer / Injuries - Is this Resident at risk for developing pressure ulcers/injuries was coded as Yes. Section M1200C entitled Skin and Ulcer/Injury Treatments - Turning and Repositioning program was coded as No.

Resident CR1's MDS, with an ARD of 6/24/24, Section M0100A entitled Determination of Pressure Ulcer Injury Risk - Resident has a pressure ulcer / injury was coded as Yes. Section M0300B1 entitled Number of Stage 2 pressure ulcers was coded 0, Section M0300C1 entitled Number of Stage 3 pressure ulcers was coded 1, and Section M0300F1 entitled Number of unstageable pressure ulcers due to coverage of wound bed by slough (dead tissue within a wound, often appearing as yellow, tan, or white material) and/or eschar (dry, dead tissue within a wound) was coded 1. Section M0150 entitled Risk of Pressure Ulcer / Injuries - Is this Resident at risk for developing pressure ulcers/injuries was coded as Yes. Section M1200C entitled Skin and Ulcer/Injury Treatments - Turning and Repositioning program was coded as No.

Resident CR1's physician orders revealed an order dated 5/07/24, for weekly skin assessments to be completed every dayshift every Tuesday. A physician order dated 5/07/24, was noted with a discontinue date of 5/09/24, for house ointment/cream after each incontinent episode for prevention and protection every shift for treatment. A physician order dated 6/14/24, revealed Doxycycline Hyclate 100 milligrams two times a day for right gluteus wound for 10 Days.

Resident CR1's progress notes dated 5/10/24, revealed Area to right buttocks reassessed and noted to be 2. 5 cm [centimeters] x 2.0 cm x 0.2 cm. It is currently a Stage 2 pressure injury. Per her daughter, she has a history of a pressure injury to this location that never completely healed. Area covered with a foam dressing.

Further progress notes for Resident CR1 dated 5/24/24, by a Wound Certified Registered Nurse Practitioner (CRNP) indicated resident was seen for wound to the right gluteus (buttocks) noted by staff on admission assessment. Wound: 1 Location: right gluteus Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: New Size: 3 cm x 2 cm x 0 cm Wound Base: 0% epithelial, 30 granulation, 70 slough, 0% eschar. Exudate: Moderate amount of Serous. Treatment: Cleanse with 0.125% Dakins solution, apply Medical grade honey. Calcium Alginate, Zinc Oxide to base of wound, secure with Bordered gauze, change daily and PRN (as needed). Continue: offloading pressure on area, side to side turning/repositioning (q 2 hrs), pressure redistribution, keep heels elevated.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0686

Level of Harm - Actual harm

Residents Affected - Few

Further progress notes for Resident CR1 dated 5/31/24, by Wound CRNP revealed wound/skin condition noted Wound Assessment Wound 1 Location: right gluteus Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: Worsening Size: 4 cm x 4 cm x 0.5 cm Wound Base: 0% epithelial, 30 granulation, 70 slough, 0% eschar. Exudate: Moderate amount of Serous. Treatment: Cleanse with 0.125% Dakins solution, apply Calcium alginate, Zinc Oxide Paste, SANTYL (NICKEL THICKNESS) to base of wound, secure with Bordered Gauze, change Daily, and PRN. Wound: 2 Location: left heel Primary Etiology: Pressure State/Severity: Stage 3 Wound Status: New Size 2 cm x 1.5 cm x 0 cm Wound Base 0 % epithelial, open dark red/purple nonblanching tissue granulation, 0% slough, 0% eschar. Surgical Wound Debridement with Treatment: Cleanse with normal saline, apply Medical grade honey, Calcium alginate, Zinc Oxide Paste to base of the wound, secure with Bordered gauze, change Daily, and PRN.

Further progress notes for Resident CR1 dated 6/21/24, by Wound CRNP revealed Right gluteal wound reclassified due to decline. Wound: 1 right gluteus Primary Etiology: Pressure Stage/Severity: Unstageable Wound Status: Worsening Size 6 cm x 6 cm x 0.5 cm Wound Base: 0% epithelial, 0% granulation, 100% slough, 0% eschar. Exudate: Moderate amount of Serous. Surgical Wound Debridement with Treatment: Cleanse with 0.125% Dakins solution, apply Zinc Oxide Paste, SANTYL (NICKEL THICKNESS), Dakins moistened fluffed gauze to base of the wound, secure with Bordered gauze, change Daily, and PRN. Wound: 2 left heel Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: improving with delayed wound closure Size 1.5 cm x 2.5 cm x 0.3 cm Wound Base: 0% epithelial, 100% granulation, 0% slough, 0% eschar. Exudate: Moderate amount of Serous. Treatment: Cleanse with 0.125% Dakins solution, apply Zinc Oxide Paste, Collagen, Silver Alginate to base of the wound, secure with ABD, Rolled gauze, change Daily and PRN.

Resident CR1's clinical record lacked evidence that an assessment of the right buttocks was completed by a RN from 5/10/24, to 5/24/24, the time the Stage Two pressure ulcer worsened to a Stage Three pressure ulcer.

Resident CR1's clinical record lacked evidence of turning/repositioning, including recommendations from the Wound CRNP dated 5/24/24, for offloading pressure on area, side to side turning/reposition (q2 hrs), pressure redistribution, keep heels elevated.

Resident CR1's clinical record lacked evidence that the physician ordered weekly skin assessments were completed from 5/14/24, to the day of discharge 6/24/24. The Stage Two pressure ulcer of the right buttocks worsened to a Stage Three pressure ulcer, and a new Stage Three pressure ulcer was discovered to the left heel during the period elapsed from 5/08/24, to 6/24/24.

The Director of Nursing (DON) confirmed lack of skin assessments for Resident CR1 during an interview at 2:26 p.m. on 8/16/24. The Nursing Home Administrator (NHA) confirmed on 8/22/24, at 3:50 p.m. the facility failed to provide skin assessments, interventions in place and monitoring for skin integrity, to prevent the development and/or worsening of pressure ulcers.

The facility failed to ensure that Resident CR1 had appropriate interventions in place and was monitored for skin integrity adequately to prevent the development of harm of a Stage Three pressure ulcer wound to right buttocks and Stage Three pressure ulcer wound to left heel.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395510	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Manor	435 North Broad Street Grove City, PA 16127

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident CR2's clinical record revealed an admitted [DATE], and discharge date of [DATE], with diagnoses that included cellulitis (bacterial skin infection) of left leg, diverticulitis (an inflammation of infection in one or more small pouches in the digestive tract), non-pressure chronic ulcer (a long-lasting open sore typically caused by poor circulation), and obesity. An Admission / Readmission Nursing Evaluation completed on 7/18/24, at 1:31 p.m. indicated Resident CR2's skin color was warm and unremarkable upon assessment with no pressure areas or evidence of pressure areas. A Braden Scale was completed as part of the admission assessment on 7/18/24, at 2:07 p.m. revealed a total score of 16, indicating Resident CR2 was at a low risk for developing pressure ulcers. The assessment further indicated Resident CR2 was at low risk for developing pressure ulcers due to slightly limited sensory perception, incontinence, limited physical activity - spends majority of shift in bed or chair, makes frequent though slight changes in body or extremity position independently, adequate nutrition, and risk for friction and shear (sliding on sheet causing skin irritation). A Bowel and Bladder Screener dated 7/23/24, indicated Resident CR2 was continent of bowel and bladder, a one-person assist, and no redness to the skin on genital, perineal, and buttocks. Resident CR2's care plan dated 5/08/24, revealed potential pressure ulcer development as focus with interventions as weekly skin assessments to be performed during regularly scheduled bath/shower per facility policy. Notify nurse immediately of any new areas of skin breakdown, redness, bruises, discoloration noted during bath or daily care. Resident CR2's MDS, with an ARD of 7/24/24, section GG0170A entitled Mobility (roll left and right: The ability to roll from lying on back to left and right side, and return to lying on the bed) was coded as requiring partial/moderate assistance of staff to complete task. Section M0100A entitled Determination of Pressure Ulcer Injury Risk - Resident has a pressure ulcer / injury was coded as No. Section M0150 entitled Risk of Pressure Ulcer / Injuries - Is this Resident at risk for developing pressure ulcers/injuries was coded as Yes. Section M1200A entitled Skin and Ulcer/Injury Treatments - Pressure reducing device for chair was coded as No, and Section M1200C entitled Skin and Ulcer/Injury Treatments - Turning and Repositioning program was coded as No. Resident CR2's physician orders revealed an order dated 7/18/24, for weekly skin assessments to be completed every dayshift every Thursday. On 7/19/24, Wound CRNP recommendations stated, continue pressure redistribution support surface, continue Foam wheelchair cushion to wheelchair, limit sitting time to 2 hours per episode, Continue: offloading pressure on area, side to side turning/repositioning (q 2 hrs), pressure distribution, keep heels elevated. Resident CR2's progress notes dated 8/04/24, stated Pts [patients] dtr [daughter] concerned re [regarding] pts open sores on buttocks. Did inform the dtr re wound care that was performed during the night. Dtr is concerned re pt going home with open sores. Informed dtr that will have wound care RN and NP assess pt before d/c [discharge]. Dtr. agrees. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove Manor	435 North Broad Street Grove City, PA 16127

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Further progress notes for Resident CR2's Wound CRNP's progress notes dated 8/09/24, stated Wounds to bilateral glutes noted to have declined on today's exam, Re-education was provided to the staff, patient regarding the patient's wound, dressing care, offloading, and general treatment recommendations. Wound: 3 Location: coccyx Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: Worsening Size: 1 cm x 1 cm 1 cm Wound Base: 100% granulation Exudate: Moderate amount of Serous. Treatment: Cleanse with 0.125% Dakins solution, apply Medical grade honey, Calcium alginate, Zinc Oxide Paste to base of the wound, secure with Bordered gauze, change Daily, and PRN. Wound: 5 Location: left gluteus Primary Etiology: Pressure State/Severity: Stage 3 Wound Status: New Size: 1 cm x 1 cm x 1 cm Wound Base: 50% granulation, 50 % slough Exudate: Moderate amount of Serous Treatment: Cleanse with 0.125% Dakins solution, apply Medical grade honey, Calcium alginate, Zinc Oxide Paste to base of the wound, secure with Bordered gauze, change Daily, and PRN. Wound: 6 Location: right gluteus Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: New Size 1 cm x 1 cm x 0.3 cm Wound Base: 50% granulation, 50% slough Exudate: Moderate amount of Serous. Treatment: Cleanse with 0.125% Dakins solution, apply Medical grade honey, Calcium alginate, Zinc Oxide Paste to base of the wound, secure with Bordered gauze, change Daily, and PRN. Resident CR2's clinical record lacked evidence of turning/repositioning, including recommendations from Wound CRNP dated 7/19/24, to limit sitting time to 2 hours per episode and to continue offloading presure on area, side to side turning/reposition (q2 hrs), pressure redistribution, keep heels elevated. Resident CR2's clinical record lacked evidence that the physician ordered weekly skin assessments were completed from 7/18/24, to the day of discharge 8/09/24 allowing a Stage Three pressure ulcer to develop on the coccyx, right buttocks, and left buttocks within a 23 day period of time. The DON confirmed the lack of skin assessments for Resident CR2 during an interview at 2:26 p.m. on 8/16/24. The NHA confirmed on 8/22/24, at 3:50 p.m. the facility failed to conduct skin assessments, and maintain interventions in place and monitoring for skin integrity, to prevent the development and/or worsening of pressure ulcers and skin conditions. The facility failed to ensure that Resident CR2 had appropriate interventions in place and was monitored for skin integrity adequately to prevent the development of actual harm of Stage Three pressure ulcer wounds to the coccyx, right buttocks, and left buttocks. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(2)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services