

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395514	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER Maybrook Hills Rehabilitation and Healthcare Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Valley View Boulevard Altoona, PA 16602	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>19102</p> <p>Based on review of Pennsylvania's Nursing Practice Act, job descriptions, and clinical records, as well as staff interviews, it was determined that the facility failed to correctly transcribe physician's orders for one of five residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals.</p> <p>A job description for registered nurses, undated, indicated that the registered nurse was to ensure that the highest degree of quality care was maintained at all times and was to provide direct nursing care as needed.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated April 3, 2024, indicated that the resident was cognitively impaired, received a diuretic (water pill), and had diagnoses that included heart failure.</p> <p>A nursing note, dated May 22, 2024, revealed laboratory results were reviewed with the Certified Registered Nurse Practitioner (CRNP - a registered nurse who has advanced education and clinical training in a health care specialty area), and new orders were received for 40 milligrams (mg) of Torsemide (water pill) twice a day for two days and 20 milliequivalents of potassium chloride (supplement) daily for three days and obtain a basic metabolic panel (BMP-blood test that checks the levels of different substances in your blood) on May 24, 2024.</p> <p>A laboratory result, dated May 24, 2024, was reviewed by the physician, and new orders were received to continue the 40 mg of Torsemide twice a day. A nursing note written by Registered Nurse 2, dated May 24, 2024, at 3:05 p.m. revealed that the laboratory results were reviewed with the physician, new orders were received to continue 40 mg of Torsemide twice a day indefinitely, and that the orders were updated.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A CRNP note, dated May 29, 2024, at 8:21 a.m., revealed that Resident 2 was fluid overloaded with 4+ pitting edema (severe swelling) of the lower extremities and that she was currently receiving 40 mg of Torsemide twice a day. The plan was to add 50 mg of Spironolactone daily to the already ordered 40 mg of Torsemide twice a day.</p> <p>Resident 2's Medication Administration Record (MAR) for May and June 2024 revealed that the resident did not receive 40 mg of Torsemide twice day from May 25 through June 7, 2024.</p> <p>Interview with the Director of Nursing on August 7, 2024, at 3:32 p.m. confirmed that the registered nurse who reviewed the laboratory results with the physician did not transcribe the new order for Torsemide into the medical record; therefore, the 40 mg of Torsemide twice a day was not administered according to the order.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>19102</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that oxygen was provided as ordered by the physician for one of five residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>The facility's policy regarding oxygen use, dated May 8, 2024, indicated that the facility was to provide oxygen as ordered by the physician.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 1, dated July 4, 2024, revealed that the resident was cognitively intact and received oxygen. A care plan for the resident, dated February 22, 2024, revealed that the resident received oxygen therapy. Physician's orders, dated July 10, 2024, included an order for the resident to receive oxygen at two liters per minute (lpm) every shift for hypoxia (low levels of oxygen in your body tissues).</p> <p>Observations of Resident 1 on August 7, 2024, at 3:11 p.m. and 3:15 p.m. revealed that the resident had oxygen in use via a concentrator (electrical machine that concentrates the oxygen from the air) at a flow rate of five (5) lpm via nasal cannula (tube that delivers oxygen through the nose).</p> <p>Interview with Licensed Practical Nurse 1 at the time of the second observation confirmed that Resident 1's oxygen flow rate was set at five lpm and should have been set at two lpm as ordered.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>19102</p> <p>Based on review of clinical records and staff interviews, it was determined that the facility failed to provide medication as ordered by the physician, resulting in a significant medication error for one of five residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated April 3, 2024, indicated that the resident was cognitively impaired, received a diuretic (water pill), and had diagnoses that included heart failure.</p> <p>A nursing note, dated May 22, 2024, revealed that laboratory results were reviewed with the Certified Registered Nurse Practitioner (CRNP - a registered nurse who has advanced education and clinical training in a health care specialty area), and new orders were received for 40 milligrams (mg) of Torsemide (water pill) twice a day for two days and 20 milliequivalents of potassium chloride (supplement) daily for three days and obtain a basic metabolic panel (BMP - blood test that checks the levels of different substances in your blood) on May 24, 2024.</p> <p>A laboratory result, dated May 24, 2024, was reviewed by the physician, and new orders were received to continue the 40 mg of Torsemide twice a day. A nursing note written by Registered Nurse 2, dated May 24, 2024, at 3:05 p.m. revealed that the laboratory results were reviewed with the physician, new orders were received to continue 40 mg of Torsemide twice a day indefinitely, and that the orders were updated.</p> <p>A CRNP note, dated May 29, 2024, at 8:21 a.m., revealed that Resident 2 was fluid overloaded with 4+ pitting edema (severe swelling) of the lower extremities and that she was currently receiving 40 mg of Torsemide twice a day. The plan was to add 50 mg of Spironolactone daily to the already ordered 40 mg of Torsemide twice a day.</p> <p>Resident 2's Medication Administration Record (MAR) for May and June 2024 revealed that the resident did not receive 40 mg of Torsemide twice day from May 25 through June 7, 2024.</p> <p>Interview with the Director of Nursing on August 7, 2024, at 3:32 p.m. confirmed that the registered nurse who reviewed the laboratory results with the physician did not transcribe the order for the Torsemide into the medical record; therefore, the 40 mg of Torsemide twice a day was not administered according to the order.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		