

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  08/28/2024
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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>31760</p> <p>Based on interviews with residents and staff, as well as observations, it was determined that the facility failed to ensure that residents could make choices about aspects of their lives that were significant to them, such as eating in the dining room with other residents, for nine of 57 residents reviewed (Residents 70, 72, 79, 125, 149, 151, 157, 162, 164).</p> <p>Findings include:</p> <p>Interview with Resident 72 on August 25, 2024, at 11:21 a.m. revealed that she likes to eat in the main dining room but has been unable to do so because the air conditioner is broken and the facility said that it would be too hot in there to have the dining room open. She indicated that the facility is waiting on a part to come to fix the air conditioner.</p> <p>During an group interview with Residents 70, 72, 79, 125, 149, 151, 157, 162, and 164 on August 26, 2024, at 2:04 p.m. the residents reported that they would like to eat in the main dining room, but they were told that they are unable to do so because the air conditioner is broken and the facility said that it would be too hot in there to have the dining room open. They indicated that the facility is waiting on a part to come to fix the air conditioner.</p> <p>The dietary's meal cart order, dated July 11, 2012, revealed that the main dining room's cart was to be delivered to the main dining room for the lunch meal at 12:12 p.m.</p> <p>An email, dated April 5, 2024, sent to the facility's ownership/management team by the Nursing Home Administrator revealed a Weekly Nursing Home Administrator report, dated March 29, 2024, to April 5, 2024. I forgot to include in my report that we have started soft opening of the main dining room and S2 unit dining room this week on Tuesdays and Thursdays. It has been a huge hit, and we will continue twice weekly throughout this month, then it will move to daily next month. This is for lunch only.</p> <p>Observations on August 25, 26, 27, and 28, 2024, during the lunch meal revealed that there were no residents eating in the main dining room during the meal and the doors were closed and locked.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Nursing Home Administrator on August 28, 2024, at 11:35 a.m. revealed that they had started with residents eating in the main dining room on Tuesdays and Thursdays, and shortly after that the air conditioning units went down. With the high temperatures outside it was decided to close the main dining room until they got quotes from vendors to decide if they were going with replacement parts or buying new units.</p> <p>Interview with the Maintenance Director on August 28, 2024, at 12:57 p.m. confirmed that he was advised by staff that the air conditioning units were not working in the main dining room. He indicated that on August 5, 2024, he had a vendor come to the facility to look at the air conditioning units. He received a quote on fixing the air conditioning units on August 23, 2024. He indicated that he is currently waiting for a quote to see if replacing the air conditioning units would be more cost effective than just repairing them. He indicated that they did not attempt any other interventions to try and keep the dining room open so that the residents could still eat in the main dining room and that it was decided to just close the main dining room down.</p> <p>Interview with the Nursing Home Administrator on August 28, 2024, at 2:33 p.m. confirmed that they did not monitor temperatures in the main dining room, they just closed it on the side of caution.</p> <p>28 Pa. Code 201.29(j) Resident Rights.</p>

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>46994</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide the required notice to the resident or the resident's representative following the end of their Medicare coverage, or failed to provide 48-hour advanced notice, for two 57 residents reviewed (Residents 201, 228).</p> <p>Findings include:</p> <p>Resident 201's medical record revealed that he began Medicare A services on March 1, 2024, and his last covered day was April 22, 2024. The medical record indicated that the facility initiated discontinuation from Medicare Part A coverage and that the resident's benefit days were not exhausted. The facility had no documented evidence that the resident was issued a Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form, or an Advance Beneficiary Notice (ABN) as required. A verbal notification was provided to the resident's responsible party on May 1, 2024, which was not 48 hours in advance. The ABN notice provided to the resident's responsible party did not include the items and services that are/are not covered under Medicaid or by the facility's per diem rate and did not include the cost of those items and services.</p> <p>Resident 228's medical record revealed that he began Medicare A services on February 7, 2024, and his last covered day was April 1, 2024. The medical record indicated that the facility initiated discontinuation from Medicare Part A coverage and that the resident's benefit days were not exhausted. A Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form and an Advance Beneficiary Notice (ABN) were signed on March 29, 2024; however, the ABN notice provided to the resident did not include the items and services that are/are not covered under Medicaid or by the facility's per diem rate and did not include the cost of those items and services.</p> <p>Interview with the Nursing Home Administrator on August 26, 2024, at 2:22 p.m. confirmed that Resident 201 was not issued a SNF Beneficiary Protection Notification Review form or an ABN timely and that the ABN forms for Residents 201 and 228 were not completed accurately and should have been.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>19102</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to notify the resident and resident's representative, in writing, regarding the reason for hospitalization for six of 57 residents reviewed (Residents 85, 96, 157, 171, 192, 218).</p> <p>Findings include:</p> <p>An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 85 revealed the resident was cognitively intact, was dependent on staff for personal care needs, had an indwelling catheter (thin tube inserted into the bladder to drain urine), and had diagnoses that included hemiplegia (paralysis of one side of the body) following a stroke.</p> <p>Nurses' notes for Resident 85, dated August 16, 2024, revealed that the resident was not looking good, was visibly shaking, and stated he felt cold. He required oxygen and had bleeding at his indwelling catheter site. The physician was notified, and the resident was sent to the emergency room for evaluation. The resident was admitted to the hospital with an elevated troponin level (blood test that signifies damage to the heart muscle) and sepsis (condition in which the body responds improperly to an infection).</p> <p>There was no documented evidence that a written notice of Resident 85's transfer to the hospital on August 16, 2024, was provided to the resident or that the resident's responsible party regarding the reason for transfer.</p> <p>A quarterly MDS assessment for Resident 96, dated August 6, 2024, revealed that the resident was understood, could understand others, and had diagnoses that included cancer and dementia.</p> <p>A nursing note for Resident 96, dated December 17, 2023, revealed that the resident stated that her chest pain was not going away and she would like to go to the emergency room . The resident was admitted with a diagnosis of chest pain.</p> <p>A nursing note for Resident 96, dated January 20, 2024, revealed that the resident was noted to continue to have a fever with a current temp of 104.3 degrees Fahrenheit (F). The physician was aware and orders were received to send the resident to emergency department for evaluation and treatment. A nursing note for Resident 96, dated January 21, 2024, revealed that the resident was admitted with sepsis (a life-threatening medical emergency that occurs when the body has an extreme response to an infection) and hypotension (low blood pressure).</p> <p>(continued on next page)</p>		

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F 0623  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>A nursing note for Resident 96, dated March 29, 2024, revealed that the resident had increased confusion and lethargy (a state of feeling tired, sluggish, or lacking energy), continued with an elevated temperature of 102.2 degrees F after receiving Tylenol (a pain reliever and a fever reducer) suppository. The resident continued to be weak, nauseated and trembling/shaking. The resident repeated several times, I'm cold, and was unable to make clear of wants and needs. Laboratory results were reviewed with the physician, and a new order was received to send the resident to emergency department for evaluation and treatment. A nursing note for Resident 96, dated March 30, 2024, revealed that the resident was admitted to the intensive care unit with septic shock (a life-threatening condition that happens when blood pressure drops to a dangerously low level after an infection) and uncontrollable hypotension.</p> <p>A nursing note for Resident 96, dated April 23, 2024, revealed that the resident was complaining of suprapubic (region of the abdomen located below the umbilical region) pain and small blood clots were noted in her brief. The resident requested to go to hospital and the physician was agreeable. A nursing note for Resident 96, dated April 24, 2024, revealed that the resident was admitted with a diagnosis of sepsis.</p> <p>There was no documented evidence that a written notice of Resident 96's transfers to the hospital on December 17, 2023; January 20, 2024; March 29, 2024; and April 23, 2024, were provided to the resident/resident's responsible party regarding the reason for transfer.</p> <p>A quarterly MDS assessment for Resident 157 revealed that the resident was cognitively intact, was independent with his personal care needs, and had diagnoses that included osteomyelitis (a serious bone infection).</p> <p>A nursing note for Resident 157, dated March 6, 2024, revealed that the resident's white blood cell (protects your body from infection) count was elevated. This was reviewed with the physician and the resident was ordered to be transferred to the emergency room for evaluation. The resident was admitted to the hospital with sepsis.</p> <p>A nursing note for Resident 157, dated May 24, 2024, revealed that the resident was diaphoretic (had excessive sweating), pale and reported having the chills. His right lower extremity remained swollen, and he had complaints of pain. The certified registered nurse practitioner (CRNP) was notified, and the resident was transferred to the emergency room for evaluation.</p> <p>There was no documented evidence that a written notice of Resident 157's transfer to the hospital on March 26, 2024, and May 24, 2024, was provided to the resident or the resident's responsible party regarding the reason for transfer.</p> <p>A quarterly MDS assessment for Resident 171, dated June 3, 2024, revealed that the resident was understood, could understand others, and had diagnoses that included cancer, end-stage renal disease (ESRD - a permanent condition where the kidneys stop working and require dialysis or a kidney transplant to stay alive), and chronic obstructive pulmonary disease (COPD - a progressive lung disease that causes breathing problems and restricted airflow).</p> <p>(continued on next page)</p>



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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note for Resident 218, dated August 2, 2024, revealed that the writer reviewed lab results with the physician, and new orders were received to send the resident to the emergency department for evaluation and treatment.</p> <p>A nursing note for Resident 218, dated August 3, 2024, revealed that the resident was admitted with a diagnosis of acute kidney injury and new onset of tremors.</p> <p>There was no documented evidence that a written notice of Resident 218's transfer to the hospital on August 2, 2024, was provided to the resident/resident's responsible party regarding the reason for transfer.</p> <p>Interview with the Nursing Home Administrator on August 27, 2024, at 3:00 p.m. indicated that she was not aware that she was to be providing letters to the resident/resident's responsible party regarding the reason for transfer.</p> <p>Interview with the Assistant Director of Nursing on August 28, 2024, confirmed that the facility did not provide a written notice to the residents or their representatives when a resident was transferred to the hospital.</p> <p>28 Pa. Code 201.25 Discharge Policy.</p> <p>28 Pa. Code 201.29(f)(g) Resident Rights.</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42079</p> <p>Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that comprehensive admission and annual Minimum Data Set assessments were completed in the required time frame for four of 57 residents reviewed (Residents 32, 128, 204, 225).</p> <p>Findings include:</p> <p>The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that an admission MDS assessment was to be completed no later than 14 days following admission, that the Assessment Reference Date (ARD - the last day of an assessment's look-back period) must be set within 366 days after the ARD of the previous comprehensive assessment, and that the assessment was to be completed no later than the ARD plus 14 calendar days.</p> <p>An admission MDS assessment for Resident 32 revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on August 2, 2024, which was 15 days after admission.</p> <p>An admission MDS assessment for Resident 128 revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on July 22, 2024, which was 18 days after admission.</p> <p>An admission MDS assessment for Resident 204 revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on July 9, 2024, which was 21 days after admission.</p> <p>An admission MDS assessment for Resident 225 revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on August 27, 2024 which was 19 days after admission.</p> <p>An interview with Nursing Home Administrator on August 27, 2024, at 9:53 a.m. confirmed that MDS assessments were not completed timely.</p> <p>An interview with Assistant Director of Nursing on August 28, 2024, at 1:30 and 2:27 p.m. confirmed that Residents 32, 128, 204, and 225's comprehensive admission MDS assessments were completed late.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p>		

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F 0637  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Assess the resident when there is a significant change in condition</p> <p>31760</p> <p>Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that comprehensive significant change Minimum Data Set assessments were completed in the required time frame for two of 57 residents reviewed (Residents 96, 171).</p> <p>Findings include:</p> <p>The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 20243, indicated that the Assessment Reference Date (ARD) was to be no later than the 14th calendar day after determination that a significant change in the resident's status occurred (determination date + 14 calendar days) and the significant change comprehensive MDS assessment was to be completed no later than the 14th calendar day after determination that significant a change in the resident's status occurred (determination date + 14 calendar days).</p> <p>A care plan for Resident 96, dated July 26, 2024, revealed that the resident required hospice care (medical care to help someone with a terminal illness) related to an end-stage illness.</p> <p>Physician's orders for Resident 96, dated July 26, 2024, included an order for the resident to be admitted to hospice.</p> <p>However, there was no documented evidence that a significant change in status MDS assessment was completed for Resident 96 after being admitted to hospice care on July 26, 2024.</p> <p>Interview with the Nursing Home Administrator on August 27, 2024, at 2:21 p.m. confirmed that the significant change comprehensive MDS assessment for Resident 96 was not completed within the required time frame.</p> <p>A social services note for Resident 171, dated January 31, 2024, revealed that the resident was admitted to hospice care with a terminal diagnosis of chronic obstructive pulmonary disease (COPD - a progressive lung disease that causes breathing problems and restricted airflow).</p> <p>Physician's orders for Resident 171, dated February 1, 2024, included an order for the resident to be admitted to hospice.</p> <p>However, there was no documented evidence that a significant change in status MDS assessment was completed for Resident 171 after being admitted to hospice care on January 31, 2024.</p> <p>Interview with the Nursing Home Administrator on August 26, 2024, at 4:00 p.m. confirmed that the significant change comprehensive MDS assessment for Resident 171 was not completed within the required time frame.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p>

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>46994</p> <p>Based on review of the Resident Assessment Instrument Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that quarterly Minimum Data Set assessments were completed within the required timeframe for four of 57 residents reviewed (Residents 33, 147, 157, 159).</p> <p>Findings include:</p> <p>The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that the assessment reference date (ARD - the last day of the assessment's look-back period) of a quarterly MDS assessment must be no more than 92 days after the ARD of the most recent assessment of any type, and the assessment was to be completed no later than the ARD plus 14 calendar days.</p> <p>A quarterly MDS assessment for Resident 33, with an ARD of June 12, 2024, was due to be completed by June 26, 2024, but was not signed as completed until June 27, 2024, which was 15 days from the ARD until completion.</p> <p>A quarterly MDS assessment for Resident 147, with an ARD of June 12, 2024, was due to be completed by June 26, 2024, but was not signed as completed until June 27, 2024, which was 15 days from the ARD until completion.</p> <p>A quarterly MDS assessment for Resident 157, with an ARD of June 8, 2024, was due to be completed by June 22, 2024, but was not signed as completed until June 27, 2024, which was 19 days from the ARD until completion.</p> <p>A quarterly MDS assessment for Resident 159, with an ARD of June 6, 2024, was due to be completed by June 20, 2024, but was not signed as completed until June 23, 2024, which was 17 days from the ARD until completion.</p> <p>An interview with the Nursing Home Administrator on August 27, 2024, at 9:53 a.m. confirmed that quarterly MDS assessments were not completed on time.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p>		

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F 0641  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	<p>Ensure each resident receives an accurate assessment.</p> <p>19102</p> <p>Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for eight of 57 residents reviewed (Residents 1, 3, 143, 148, 171, 182, 192, 194).</p> <p>Findings include:</p> <p>The Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, revealed that Section N0415F was to be coded (1) if an antibiotic medication was administered while a resident at the facility during the seven-day assessment period.</p> <p>Physician's orders for Resident 1, dated April 28, 2023, included an order for the resident to receive 1 gram of Hiprex (an antibiotic) twice a day for recurrent urinary tract infections.</p> <p>Review of the Medication Administration Record (MAR) for Resident 1, dated August 2024, revealed that the resident was administered 1 gram of Hiprex from August 1 through 28, 2024.</p> <p>An annual MDS assessment for Resident 1, dated August 10, 2024, revealed that Section N0415 was not coded (1), indicating that the resident did not receive an antibiotic during the seven-day assessment period.</p> <p>Physician's orders for Resident 192, dated May 31, 2024, included an order for the resident to receive 300 mg of Cefdinir (an antibiotic) twice a day for a urinary tract infection.</p> <p>Review of the MAR for Resident 192, dated June 2024, revealed that the resident was administered 300 mg of Cefdinir from June 1 through 7, 2024.</p> <p>A quarterly MDS assessment for Resident 192, dated June 10, 2024, revealed that Section N0415 was not coded (1), indicating that the resident did not receive an antibiotic during the seven-day assessment period.</p> <p>The RAI User's Manual, dated October 2023, revealed that if a wander/elopement alarm was used, then Section P0200E was to be coded as (0) not used, (1) used less than daily, or (2) used daily.</p> <p>Physician's orders for Resident 3, dated April 4, 2024, included orders for the resident to use a wanderguard (alarm that sounds when approaching exits) and to check for proper function every evening and to check for placement every shift.</p> <p>The resident's Treatment Administration Record (TAR) for August 2024 revealed that a wander/elopement alarm was used from August 1 through 25, 2024.</p> <p>However, an annual MDS assessment for Resident 3, dated August 3, 2024, revealed that Section P0200E was coded with a (0), indicating that the resident did not use a wander/elopement alarm.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The RAI User's Manual, dated October 2023, revealed that Section O0110G1b (non-invasive mechanical ventilator) was to be checked if a CPAP/BIPAP device (respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle) was used while a resident within the last 14 days and Section O0110J1b was to be checked if the resident was receiving dialysis treatment while a resident within the last 14 days.</p> <p>Physician's orders for Resident 143, dated March 16, 2024, included an order for the resident to use a BIPAP (bilevel positive airway pressure) at bedtime and physician orders, dated May 1, 2024, included an order for the resident to receive dialysis three times a week.</p> <p>Review of the TAR for Resident 143, dated June 2024, revealed that the resident used a BIPAP device from June 1 through 30, 2024. Dialysis progress notes revealed Resident 143 received dialysis on June 14, 17, 19 and 21, 2024.</p> <p>An annual MDS for Resident 143, dated June 22, 2024, revealed that Section O0110G1b was not checked, indicating that the resident did not use a BIPAP device within the last 14 days while a resident and Section O0110J1b was not checked, indicating that the resident did not receive dialysis treatment within the last 14 days while a resident.</p> <p>Physician's orders for Resident 182, dated June 25, 2024, included an order for the resident to use a CPAP (continuous positive airway pressure) at bedtime for sleep apnea (disorder that causes breathing to stop or become shallow during sleep).</p> <p>An admission MDS assessment for Resident 182, dated June 30, 2024, revealed that Section O0110G1b was not checked, indicating that the resident did not use a CPAP device within the last 14 days while a resident.</p> <p>Review of the MAR for Resident 182, dated June 2024, revealed that the resident used a CPAP device from June 25 through 30, 2024.</p> <p>The RAI User's Manual, dated October 2023, revealed that Section N0415 (high risk drug classes) A (antipsychotic) was to be coded (1) if an antipsychotic (drugs used to treat psychosis-related conditions and symptoms) medication was administered while a resident at the facility during the seven-day assessment period.</p> <p>Physician's orders for Resident 148, dated November 30, 2023, included for the resident to receive 15 milligrams (mg) of olanzapine (an antipsychotic) one time a day for schizophrenia (mental illness that affects how a person thinks, feels, and behaves).</p> <p>Review of the MAR for Resident 148, dated August 2024, revealed that the resident was administered 15 mg of olanzapine all seven days of the seven-day assessment period.</p> <p>A quarterly MDS for Resident 148, dated August 14, 2024, revealed that Section N0415A was not coded (1), indicating that the resident did not receive an antipsychotic during the seven-day assessment period.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The RAI User's Manual, dated October 2023, revealed that the intent of Section O Special treatments, Procedures, and Programs was to identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods. Section O0110 K1 (Hospice Care) was to be checked if the services were received while as a resident.</p> <p>A social services note for Resident 171, dated January 31, 2024, revealed that the resident was admitted to hospice care with a terminal diagnosis of chronic obstructive pulmonary disease (COPD - a progressive lung disease that causes breathing problems and restricted airflow).</p> <p>Physician's orders for Resident 171, dated February 1, 2024, included an order for the resident to be admitted to hospice.</p> <p>A quarterly MDS assessment for Resident 171, dated March 2, 2024, revealed that Section O0110 K1 (Hospice Care) was not checked, indicating that the resident did not receive hospice care while a resident.</p> <p>The RAI User's Manual, dated October 2023, revealed that Section O0110C1b (oxygen) was to be checked if oxygen was used while a resident within the last 14 days.</p> <p>Physician's orders for Resident 194, dated July 1, 2024, included an order for the resident to receive 2 liters per minute of oxygen.</p> <p>An admission MDS assessment for Resident 194, dated July 5, 2024, revealed that Section O0110C1b was not checked, indicating that the resident did not use oxygen within the last 14 days while a resident.</p> <p>Review of the MAR for Resident 194, dated July 2024, revealed that the resident used oxygen from July 1 through 31, 2024.</p> <p>Interview with the Nursing Home Administrator on August 28, 2024, at 10:23 a.m. confirmed that the MDS assessments on the dates mentioned above were coded incorrectly.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>19102</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to develop care plans to address individualized resident care needs for one of 57 residents reviewed (Resident 182).</p> <p>Findings include:</p> <p>The facility's policy regarding care plans, dated January 22, 2019, indicated that the facility would develop a written care plan that was individualized for each resident and address goals, actual and potential problems, needs, strengths, and individual preferences of the resident.</p> <p>An admission MDS assessment for Resident 182, dated June 30, 2024, revealed that the resident was cognitively impaired and required assistance from staff for daily care needs. Physician's orders for Resident 182, dated June 25, 2024, included an order for the resident to use a CPAP (continuous positive airway pressure) at bedtime for sleep apnea (disorder that causes breathing to stop or become shallow during sleep).</p> <p>Review of the Medication Administration Record (MAR) for Resident 182, dated August 2024, revealed that the resident used a CPAP device at bedtime from August 1 through 26, 2024.</p> <p>As of August 26, 2024, there was no documented evidence that a care plan was developed that included individualized interventions to address Resident 182's care needs related to the use of a CPAP machine.</p> <p>Interview with the Assistant Director of Nursing on August 27, 2024, at 2:40 p.m. confirmed that Resident 182 did not have a care plan in place to address the use of a CPAP machine at bedtime and a care plan should have been developed.</p> <p>28 Pa. Code 211.10(d) Resident Care Plans.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>46994</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in residents' care needs for two of 57 residents reviewed (Residents 125, 191).</p> <p>Findings include:</p> <p>The facility's policy regarding care plans, dated May 8, 2024, indicated that the facility would develop a written care plan that was individualized for each resident and address goals, actual and potential problems, needs, strengths, and individual preferences of the resident.</p> <p>A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 125, dated June 2, 2024, revealed that she was cognitively intact, was dependent on staff for personal hygiene needs, and had diagnosis that included having a left hip fracture.</p> <p>The care plan for Resident 125, dated July 12, 2024, indicated that the resident was receiving anticoagulant (blood thinner) therapy for a diagnosis of atrial fibrillation (irregular heartbeat).</p> <p>Review of the Medication Administration Record (MAR) for Resident 125, dated August 2024, revealed no documented evidence that the resident received any anticoagulant medication.</p> <p>Interview with the Assistant Director of Nursing on August 28, 2024, at 12:40 p.m. revealed that Resident 125 was no longer taking an anticoagulant and her care plan should have been revised to reflect that; however, it was not.</p> <p>An admission MDS assessment for Resident 191, dated July 23, 2024, revealed that the resident was cognitively impaired, was dependent on staff for all care needs, had diagnosis that included dementia, and had feeding tube (flexible plastic tube placed into the stomach or bowel to help provide nutrition).</p> <p>Physician's orders for Resident 191, dated August 10, 2024, included for the resident to receive a 260 milliliter (ml) bolus (a method of tube feeding that involves delivering large amounts of formula over a short period of time) feeding of Jevity 1.2 (type of nutritional tube feeding) every four hours for nutrition.</p> <p>The care plan for Resident 191, dated July 17, 2024, indicated that the resident was at risk for malnutrition and received tube feedings, and staff were to administer Jevity 1.2 tube feeding at 65 ml per hour.</p> <p>Interview with the Assistant Director of Nursing on August 28, 2024, at 12:20 p.m. revealed that Resident 191's care plan was not updated when her tube feeding orders were changed and it should have been.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 201.24(e)(4) Admission Policy.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>19102</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that medications were provided as ordered by the physician for two of 57 residents reviewed (Residents 2, 143).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated May 26, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included heart failure (a serious condition that occurs when the heart cannot pump enough blood and oxygen to the body's organs). A care plan for the resident, dated June 3, 2024, revealed that the resident was on an as needed diuretic (a drug that increases urine production, which helps the body get rid of extra salt and fluid) related to edema (swelling caused by fluid trapped in the body's tissues). Staff was to administer her medications as ordered.</p> <p>Physician's orders for Resident 2, dated June 1, 2024, included an order for staff to weigh the resident daily, and if the resident's weight was up two pounds or five pounds in one week staff was to administer 40 milligrams (mg) of Lasix (used to treat edema due to heart failure) along with 20 milliequivalent (mEq) of Potassium (a mineral that your body needs to work properly)</p> <p>A review of Resident 143's Medication Administration Record (MAR) for July 2024 revealed that the resident's weight on July 10, 2024, was 182.8 pounds; on July 11, 2024, the resident's weight was 186.4 pounds (3.6 pound increase); on July 28, 2024, the resident's weight was 181.8 pounds; and on July 29, 2024, the resident's weight was 185.2 pounds (3.4 pound increase). However, there was no documented evidence that staff had administered the Lasix and Potassium as ordered.</p> <p>Physician's orders for Resident 2, dated May 22, 2024, included an order for the resident to receive two 5-mg tablets of Midodrine (a medication that treats low blood pressure) every eight hours for hypotension (low blood pressure) and was to be held if the systolic blood pressure (the top number in a blood pressure reading) was greater than 130 millimeters of mercury (MmHg).</p> <p>A review of Resident 143's MAR for July and August 2024 revealed that staff administered the two 5-mg tablets of Midodrine when the resident's blood pressure was 136/82 MmHg at 6:00 a.m. on July 15, 2024; 134/78 MmHg at 2:00 p.m. on July 23, 2024; 132/72 MmHg at 10:00 p.m. on July 12, 2024; 132/76 MmHg at 10:00 pm. on July 16, 2024; 132/84 MmHg at 10:00 p.m. on July 22, 2024; 132/80 MmHg at 6:00 a.m. on August 13, 2024; and 136/80 MmHg at 10:00 p.m. on August 20, 2024.</p> <p>Interview with the Assistant Director of Nursing on August 27, 2024, at 12:33 p.m. confirmed that Resident 2 did not receive the Lasix and Potassium as ordered on the above dates, and also confirmed that the resident received the Midodrine on the above dates and that staff should have held the medication as ordered.</p> <p>An annual MDS for Resident 143, dated June 22, 2024, revealed the resident was cognitively intact and had diagnoses of diabetes and renal failure. Physician's orders, dated May 1, 2024, included an order for the resident to receive dialysis three times a week.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	<p>Physician's orders for Resident 143, dated December 28, 2023, included orders for the resident to receive 36 units of Insulin Aspart (fast acting insulin) subcutaneously (SQ-beneath the skin) with meals for diabetes; orders dated January 16, 2024 for the resident to receive two tablets of 800 milligrams (mg) of Renvela (used to control phosphorous levels) with meals for dialysis; and orders dated February 6, 2024, for the resident to receive 36 units Insulin Glargine SQ one time a day with lunch.</p> <p>A review of Resident 143's MAR for August 2024 revealed that the resident did not receive 36 units of Insulin Aspart, 1600 mg of Renvela, and 36 units of Insulin Glargine on August 2 at 12:46 p.m., August 19 at 2:56 p. m., and August 21, 2024, at 12:47 p.m. due to being at dialysis.</p> <p>Interview with the Assistant Director of Nursing on August 28, 2024, at 12:52 p.m. confirmed that Resident 143 did not receive Insulin Aspart, Renvela, and Insulin Glargine on the mentioned dates and times due to being at dialysis, and that the medications should have been administered upon his return.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		

**Department of Health & Human Services  
Centers for Medicare & Medicaid Services**

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43856</p> <p>Based on review of clinical records and the facility's investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that the residents' environment remained as free from falls as possible and failed to develop and implement interventions to prevent falls for one of 57 residents reviewed (Resident 165) who had a history of falling.</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 165, dated August 6, 2024, revealed that the resident was cognitively impaired, required extensive assistance for daily care needs and assistance for transfers, had a history of falls, and had diagnoses that included lower back pain, difficulty walking, and dementia.</p> <p>A nursing note for Resident 165, dated August 22, 2024, at 8:20 p.m., revealed that the resident had a fall out of her wheelchair to the side of her bed. Resident 165 was assessed and had a red, swollen right wrist with no injuries as evidenced by an X-ray on August 22, 2024. An incident report for Resident 165, dated August 22, 2024, revealed that after Resident 165 was assessed she was assisted to her wheelchair and taken to the nurses' station. There was no documented evidence that a new intervention was put in place to prevent future falls.</p> <p>A nursing note for Resident 165, dated August 25, 2024, at 8:30 a.m., revealed that the resident had a fall to the right side of her bed. Resident 165 was assessed and had no injuries. An incident report for Resident 165, dated August 25, 2024, revealed that the bed alarm was sounding at the time of the fall. Resident 165 was assessed, assisted to her wheelchair, and taken in the hall for close observation. There was no documented evidence that a new intervention was put in place to prevent future falls.</p> <p>An interview with the Assistant Director of Nursing on August 28, 2024, at 12:19 a.m. confirmed that there were no new interventions put in place to prevent future falls on the above mentioned dates and there should have been.</p> <p>An interview with the Nursing Home Administrator on August 28, 2024, at 3:48 p.m. confirmed that new interventions were not put in place to prevent future falls for Resident 165 on the above mentioned dates and there should have been.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>31760</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that enteral feedings (feeding through a tube inserted directly into the stomach) were administered in accordance with physician's orders and failed to ensure that residents who were receiving enteral feedings received appropriate treatment and services to prevent complications for two of 57 residents reviewed (Residents 20, 56).</p> <p>A facility policy for tube feeding, dated May 8, 2024, revealed that it is the policy and procedure to provide nourishment to the resident who is unable to obtain nourishment orally. The procedure for administering tube feeding includes to check for residual (the amount of gastric fluid in the stomach between feedings) by pulling back no more than 150 cubic centimeters (cc). Note the amount of residual if any. Return the gastric contents back into the stomach and clamp the gastric tube.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 20, dated August 3, 2024, revealed that the resident was usually understood, could usually understand others, and had a feeding tube. A care plan for the resident, dated July 18, 2022, revealed that the resident was at risk for malnutrition due to need for tube feeding, thickened fluids, mechanically altered diet, and poor intake at times. Staff was to provide the resident with her tube feed as ordered. The resident was to receive Jevity 1.5 (a type of nutritional tube feeding) if she consumed less than 50 percent of her meal.</p> <p>Physician's orders for Resident 20, dated November 24, 2023, included an order for the resident to receive 237 milliliters (ml) of Jevity 1.5 if the resident ate less than 50 percent of each meal.</p> <p>Review of the Medication Administration Record (MAR) for Resident 20, dated July and August 2024, revealed that staff did not administer the 237 ml of Jevity 1.5 to the resident on July 6, 2024, at 1:00 p.m. after consuming 0 to 25 percent of her meal; staff administered the 237 ml of Jevity 1.5 on July 14, 2024, at 1:00 p.m. after consuming 76 to 100 percent of her meal; July 23, 2024, at 6:00 p.m. after consuming 51 to 75 percent of her meal; August 7, 2024, at 6:00 p.m. after consuming 51 to 75 percent of her meal; and on August 8, 2024, at 8:00 a.m. after consuming 76 to 100 percent of her meal.</p> <p>Interview with the Assistant Director of Nursing on August 28, 2024, at 12:50 p.m. confirmed that Resident 20 was not receiving her tube feedings as ordered by the physician</p> <p>A quarterly MDS for Resident 56, dated May 15, 2024, revealed that the resident was cognitively impaired, was dependent on staff for eating and personal hygiene needs, had diagnoses that included dementia, and had a feeding tube.</p> <p>Physician's orders for Resident 56, dated July 3, 2024, included an order for the resident to receive a 240-milliliter (ml) bolus (a method of tube feeding that involves delivering large amounts of formula over a short period of time) of Isosource 1.5 (a type of nutritional tube feeding) through her feeding tube after meals if she consumed less than 50 percent of her meal by mouth.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A care plan for Resident 56, dated June 7, 2022, indicated that the resident needed assistance in maintaining or improving her nutritional status. Staff were to check residual and positioning of her feeding tube prior to administering a bolus of 250 ml of Isosource 1.5 if she consumed less than 50 percent of each meal daily.</p> <p>Review of meal intake records for Resident 56, dated July 2024 and August 2024, revealed that on July 5, 2024, at 9:00 a.m. and 1:00 p.m.; July 6, 2024, at 9:00 a.m. and 1:00 p.m.; July 7, 2024, at 9:00 a.m. and 6:00 p.m.; July 8, 2024, at 9:00 a.m.; August 4, 2024, at 1:00 p.m.; August 17, 2024, at 1:00 p.m.; and August 18, 2024, at 1:00 p.m., the resident consumed less than 50 percent of her meal. Review of the Medication Administration Record (MAR) for Resident 56, dated July and August 2024, revealed no documented evidence that the resident was provided a 240 ml bolus of Isosource 1.5 on the above-mentioned dates and times when the resident consumed less than 50 percent of her meal by mouth.</p> <p>Review of meal intake records for Resident 56, dated July and August 2024 revealed that on July 12, 2024, at 6:00 p.m.; July 15, 2024, at 1:00 p.m.; July 18, 2024, at 6:00 p.m.; July 19, 2024, at 6:00 p.m.; August 3, 2024, at 1:00 p.m.; and August 4, 2024, at 9:00 a.m. revealed that the resident consumed greater than 50 percent of her meal. Review of the MAR for July and August revealed that the resident was provided a 240 ml bolus of Isosource 1.5 on these dates and times.</p> <p>There was no documented evidence that staff were checking residual and documenting the amounts of residual prior to administering the tube feeding per facility policy.</p> <p>Interview with the Assistant Director of Nursing on August 28, 2024, at 2:47 p.m. confirmed that Resident 56 was not receiving her tube feedings as ordered by the physician and that staff were not checking and documenting residual per the facility's policy and the resident's care plan.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		

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F 0699  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>19102</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents were assessed and received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD) (a mental and behavioral disorder that develops related to a terrifying event) for one of 57 residents reviewed (Resident 46).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 46, dated July 3, 2024, indicated that the resident was moderately cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included depression and PTSD. A review of Resident 43's care plan, dated July 9, 2024, indicated that the resident had PTSD and depression.</p> <p>There was no documented evidence the facility identified Resident 46's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring.</p> <p>Interview with the Assistant Director of Nursing on August 28, 2024, at 1:28 p.m. revealed that the facility was not completing trauma informed care assessments.</p> <p>28 Pa Code 201.24(e)(4) Admission Policy.</p> <p>28 Pa Code 211.12(a)(d)(3)(5) Nursing Services.</p> <p>28 Pa. Code 211.16(a) Social Services.</p>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>31760</p> <p>Based on a list of nurse aides provided by the facility and their personnel files, as well as staff interviews, it was determined that the facility failed to ensure that nurse aide performance evaluations were completed annually based on the hire dates for three of three nurse aides reviewed (Nurse Aide 1, Nurse Aide 2, Nurse Aide 3).</p> <p>Findings include:</p> <p>A review of the personnel file for Nurse Aide 1 revealed a hire date of August 11, 1998, with a performance evaluation completed on August 12, 2024. However, there was no documented evidence that her annual performance evaluation was completed as required in August 2023.</p> <p>A review of the personnel file for Nurse Aide 2 revealed a hire date of July 2, 2008, with a performance evaluation completed on June 28, 2024. However, there was no documented evidence that his annual performance evaluation was completed as required in July 2023.</p> <p>A review of the personnel file for Nurse Aide 3 revealed a hire date of August 12, 2018, with a performance evaluation completed on August 12, 2024. However, there was no documented evidence that her annual performance evaluation was completed as required in August 2023.</p> <p>Interview with the Nursing Home Administrator on August 28, 2024, at 4:32 p.m. confirmed that there was no documented evidence that Nurse Aide 1, Nurse Aide 2, and Nurse Aide 3 had annual performance evaluations completed as required.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.</p> <p>28 Pa. Code 201.20(a)(c) Staff Development.</p>		

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F 0761  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>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.</p> <p>31760</p> <p>Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that controlled medications (drugs with the potential to be abused) were properly secured in the medication cart for one of 57 residents reviewed (Resident 14) and failed to ensure that medications were appropriately labeled for one of 57 residents reviewed (Resident 47).</p> <p>The facility's policy for medication storage dated May 8, 2024, included that all controlled drugs are stored under double-lock and key.</p> <p>Physician's orders for Resident 14, dated August 25, 2024, included an order to give the resident 0.5 milligrams (mg) of Clonazepam every eight hours for anxiety.</p> <p>Observations of the Iris Hall medication cart on August 27, 2024, at 8:39 a.m. revealed that the second drawer from the top of the medication cart had one medicine cup in it containing one round yellow pill. There was no name or label attached to the medication or cup. An interview with Licensed Practical Nurse 4 at the time of the observation revealed that the medication was a controlled medication called Clonazepam (controlled medication that can be used to treat anxiety) that was already signed out of a different medication cart and intended to be given to a Resident 14 during the morning medication pass. The medication cart she was using was not used on all shifts; therefore, it did not contain its own controlled medication drawer.</p> <p>Interview with the Nursing Home Administrator on August 27, 2024, at 2:35 p.m. confirmed that medications should not be prepared ahead of time and stored unlabeled in a medication cart and that narcotic medication should be stored behind a double lock.</p> <p>The facility's policy regarding medication labeling, dated May 8, 2024, indicated that it is the policy and procedure of this facility to ensure that all medications maintained in the facility are properly labeled and in accordance with current state and federal regulations. Labels for individual drug containers must include directions for use. Only the issuing pharmacy may place a drug label on a medication container. The pharmacy must be informed of any changes in directions for the use of a drug. Drugs dispensed by physicians must be labeled in accordance with established procedures. Only physicians or pharmacists may change medication labels.</p> <p>Physician's orders for Resident 47, dated March 9, 2024, included an order for the resident to receive 17 grams (gms) of Miralax (a gentle laxative designed to relieve occasional constipation) in eight ounces (oz) of water daily via peg tube (a tube inserted through the skin and the stomach wall).</p> <p>Observations during the medication administration on August 27, 2024, at 8:43 a.m. revealed that Licensed Practical Nurse 5 prepared Resident 47's Miralax and administered the Miralax via mouth. The label on the Miralax indicated that the resident was to receive 17 gms of Miralax in eight oz of water daily via peg tube.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Licensed Practical Nurse 5 on August 27, 2024, at 8:41 a.m. indicated that Resident 47 does not have a peg tube anymore, and there should have been a change of direction sticker on the label for the Miralax.</p> <p>Interview with the Assistant Director of Nursing on August 27, 2024, at 1:46 p.m. confirmed that there should have been a change in direction label Resident 47's Miralax.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(1) Nursing Services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43856</p> <p>Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that food was served under sanitary conditions and failed to ensure that dietary staff wore appropriate hair and beard coverings in the kitchen.</p> <p>Findings include:</p> <p>The facility's policy regarding hair net policy for nursing home kitchen staff, dated May 8, 2024, revealed that kitchen staff should maintain personal hygiene. Hair should be clean and neatly tied or pinned back under a hair net. Facial hair, such as beards, must also be covered with a beard net.</p> <p>Observations in the main kitchen during the lunch meal tray line on August 27, 2024, at 11:45 a.m. revealed that Dietary Worker 6, Dietary Worker 7, Dietary Worker 8, Dietary Worker 9, Dietary Worker 10, and Dietary Worker 11 had beards that were not covered with beard nets/covers during tray line. Dietary Worker 12 and Dietary Worker 13 did not have their hair completely under a hair net during food preparation.</p> <p>Interview with the Dietary Manager on August 27, 2024, at 11:47 a.m. confirmed that dietary workers should have beards covered with a beard net and hair should be completely under a hair net while in the kitchen.</p> <p>Interview with the Nursing Home Administrator on August 27, 2024, at 2:49 p.m. confirmed that dietary workers who have beards should be wearing beard covers and that all hair should be covered with a hair net while in the kitchen.</p> <p>28 Pa. Code 211.6(f) Dietary Services.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>42079</p> <p>Based on review of clinical records and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that clinical records were complete and accurately documented for one of 57 residents reviewed (Resident 225).</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 225, dated August 15, 2024, indicated that the resident was understood, could understand, was cognitively intact, required assistance with daily care tasks, and required hemodialysis treatments (procedure that removes waste and excess fluid from the blood when the kidneys are unable to do so).</p> <p>A care plan for Resident 225, dated August 9, 2024, indicated that she was at nutritional risk due to the need for more protein due to end-stage renal disease and hemodialysis. Resident 225 had an intervention to monitor, record, and report any muscle wasting or significant weight loss to the physician.</p> <p>Physician's order for Resident 225, dated August 9, 2024 indicated that the resident was ordered daily weights for health monitoring and to notify the physician if there was a four-pound or greater weight gain.</p> <p>There was no documentation in Resident 225's clinical record to indicate that daily weights were documented for August 10, 11, 17, and 18, 2024.</p> <p>Interview with the Assistant Director of Nursing on August 28, 2024, at 5:30 p.m. confirmed that there was no documented evidence in Resident 225's clinical record to indicate that daily weights were documented for the dates listed above. Facility staff were obtaining the weight, but there was no area in the clinical record to chart the weight, nor did staff enter the daily weights into the vitals section.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p> <p>28 Pa. Code 211.12(d)(1) Nursing Services.</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>42079</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to obtain the required information from the contracted hospice provider for one of 57 residents reviewed (Resident 128).</p> <p>Findings include:</p> <p>The hospice contract for Family Hospice dated, January 1, 2020, revealed that the agency shall provide the facility with a copy for each hospice patient of the most recent plan of care specific to each patient, the physician certification and recertification of the terminal illness specific to each patient.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs)for Resident 128, dated July 10, 2024, revealed that the resident was rarely understood and had a memory problem, was dependent on staff for her daily care needs, and had a diagnosis of dementia. A care plan for Resident 128, dated August 2, 2024, indicated that the resident was receiving hospice care.</p> <p>A hospice Election of Benefit document (a form signed to indicate that the individual waives all rights to traditional Medicare Part A payments for treatment related to the terminal illness) for Resident 128, dated September 9, 2022, revealed that the resident was receiving hospice services effective September 9, 2022. As of August 27, 2024, there was no documented evidence in the resident's clinical record, or in the hospice provider's clinical record, that the facility obtained the current hospice recertification of terminal illness or plan of care from the hospice provider for the certification period.</p> <p>Interview with the Nursing Home Administrator on August 27, 2024, at 2:18 p.m. confirmed that there was no documented evidence in Resident 128's clinical record, or in the hospice provider's clinical record, that the facility obtained the hospice recertification of terminal illness and plan of care from the hospice provider for the certification period of June 30, 2024, through August 28, 2024.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		









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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An admission MDS assessment for Resident 204, dated August 2, 2024, revealed that the resident was understood, could understand, was cognitively impaired, was dependent on staff for eating, and had a feeding tube (a soft flexible plastic tube inserted in the gastrointestinal tract to provide nutrition). A care plan for Resident 204, dated June 20, 2024, indicated the resident had EBP for a percutaneous endoscopic gastrostomy tube (PEG - type of feeding tube). Physician's orders for Resident 204, dated June 22, 2024, included an order for the resident to be administered a bolus of 237 milliliters (ml) of Jevity 1.5 calorie six times a day for enteral feedings.</p> <p>Observations on August 27, 2024, at 2:53 p.m. revealed that Licensed Practical Nurse 18 was providing a bolus feeding to Resident 204 only wearing gloves. Interview with Licensed Practical Nurse 18 on August 28, 2024, at 3:40 p.m. confirmed that she should have worn a gown while providing a feeding tube feedings for residents with EBP.</p> <p>Interview with the Licensed Practical Nurse Manager and Infection Preventionist 15 on August 28, 2024, at 9:43 a.m. confirmed that staff should be wearing a gown when providing care for residents with EBP.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		