

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395524	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Grove at New Castle, The		STREET ADDRESS, CITY, STATE, ZIP CODE 715 Harbor Street New Castle, PA 16101	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41309</p> <p>Based on review of clinical records and staff interviews, it was determined that the facility failed to implement care and services identified on a comprehensive care plan regarding provision of care for activities of daily living (ADL) for one of 17 residents reviewed (Resident R41).</p> <p>Findings include:</p> <p>Review of Resident R41's clinical record revealed an admitted [DATE], with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), major depressive disorder (a mental disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), history of seizures, vascular dementia (brain damage cause by multiple strokes), history of transient ischemic attacks and cerebral infarction (temporary blockage of blood flow to the brain), altered mental status, other abnormalities of gait and mobility, and type one diabetes mellitus (a condition where the pancreas makes little to no insulin, leading to high blood sugar levels).</p> <p>Review of R41's Minimum Data Set (MDS-a periodic assessment of resident care needs) Assessment Section GG Functional Abilities and Goals last updated 2/21/2024, revealed that Section GG0130 Self-care revealed Shower/bathe self: the ability to bathe self, including washing, rinsing, and drying self, identified that Resident R41 required partial/moderate assistance; Section GG0170 FF: tub/shower transfer: the ability to get in and out of a tub/shower revealed that Resident R41 required partial/moderate assistance.</p> <p>Review of Resident R41's ADL related care plan originally dated 10/12/2020 and last reviewed 3/19/2024, revealed resident has an ADL self-care performance deficit. Bathing required an assist of one staff member with bathing/showering.</p> <p>Review of an incident regarding Resident R41 revealed he/she was left unattended in the tub/shower area on 4/10/24, with subsequent fall with injury based on a physician's order dated 2/12/2021 for transfers independently.</p> <p>During an interview on 6/6/2024, at approximately 3:30 p.m. with the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed the inconsistencies in Resident R41's clinical record and that the ADL care plan was not implemented accurately.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interviews conducted with facility staff members on 6/7/2024, between 10:25 am. and 10:40 a.m. revealed that prior to showering residents, the resident care plan for ADL's is to be reviewed to determine proper transfer/assistance level information to ensure resident safety.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>		

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<p>F 0689</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41309</p> <p>Based on review of resident rights, clinical records, and facility documentation, and staff interview, it was determined that the facility failed to provide proper resident assistance during bathing that resulted in a fall with actual harm of a fracture of the right shoulder for one of 17 residents reviewed (Resident R41).</p> <p>Findings include:</p> <p>Review of Statement of Resident Rights revealed the resident has the right to a safe, clean, comfortable, homelike environment, including but not limited to: (a) receiving treatments and support for daily living safely; (d) ensuring that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>Review of Resident R41's clinical record revealed an admitted [DATE], with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), major depressive disorder (a mental disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), history of seizures, vascular dementia (brain damage cause by multiple strokes), history of transient ischemic attacks and cerebral infarction (temporary blockage of blood flow to the brain), altered mental status, other abnormalities of gait and mobility, and type one diabetes mellitus (a condition where the pancreas makes little to no insulin, leading to high blood sugar levels).</p> <p>Review of Resident R41's Activities of Daily Living (ADL) related care plan originally dated 10/12/2020 and last reviewed 3/19/2024, revealed resident has an ADL self-care performance deficit. Bathing required an assist of one staff member with bathing/showering.</p> <p>Review of R41's Minimal Data Set (MDS-a periodic assessment of resident care needs) Assessment Section GG Functional Abilities and Goals last updated February 21, 2024, revealed that Section GG0130 Self-care revealed Shower/bathe self: the ability to bathe self, including washing, rinsing, and drying self, identified that Resident R41 required partial/moderate assistance; Section GG0170 FF: tub/shower transfer: the ability to get in and out of a tub/shower revealed that Resident R41 required partial/moderate assistance.</p> <p>Review of Resident R41's progress notes from 4/10/2024, at 2:24 p.m. revealed, resident was found on floor by aide. Resident slipped and fell getting out of tub. He fell on his right arm and now has limited range of motion. Resident assessed, no skin tears, bruises, or red marks noted to right arm. VSS [vital signs stable] recorded. Hoyer lift [type of mechanical lift] used to assist resident up into chair. Resident is his own POA [power of attorney].</p> <p>Review of Resident R41's x-ray report of right shoulder dated 4/11/2024, revealed a comminuted (partial or complete break) fracture of the right shoulder.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON) on 6/6/2024, at approximately 1:30 p.m., it was confirmed that a physical therapist employee put the resident in the tub room, set him up by himself and left the resident unattended to take a bath.</p> <p>Review of a witness statement by Physical Therapist Assistant (PTA) Employee E1, stated On 4/10/2024, as I was exiting the tub room on west with another resident, [Resident R41], was waiting outside of the door clothes and body wash in hand. He asked to be let in to take his shower. Therapy documentation at this time reflects a set up status for ADL's, transfers, and ambulation so I let [Resident R41] into the shower room, as he has demonstrated good safety with set up.</p> <p>Review of a witness statement dated 4/10/2024, at 12:20 p.m. from Nurse Aide (NA) Employee E2, who found Resident R41 in the shower room on 4/10/2024, revealed, while waiting for trays, [Resident R41] asked to be let into the tub room but I told him to wait because therapy just went in with someone and lunch was coming. During the middle of lunch, the tub room call light went off and I was confused because I did not know anyone was in there. I went to go check and found [Resident R41] on his butt on the floor. I went to get his Nurse Aide and we went to assess him. After a few attempts to stand him up we used a Hoyer lift to get him into a sitting position and into a shower chair.</p> <p>During an interview on 6/7/2024, at 10:23 a.m. NA Employee E3 revealed that the nursing staff receives a list of residents that are to get showers each shift every day. They check and follow the resident care plan and tasks on set up and assistance with baths and transfers. NA Employee E3 revealed that residents are not left unmonitored in the shower regardless of their assist levels for safety purposes.</p> <p>An interview conducted with Registered Nurse (RN) Employee E4 on 6/7/2024, at 10:25 a.m. revealed that it is not the practice of the nursing staff to leave residents in the shower or tub room unattended. Staff should always be aware someone is in the tub room and close to watch or monitor resident for safety. Resident plans of care are reviewed for levels of assistance and care with baths.</p> <p>An interview with Licensed Practical Nurse (LPN) Employee E5 on 6/7/2024, at 10:30 a.m. revealed that care plans are reviewed for the levels of care and assistance with residents when taking a bath. LPN Employee E4 stated it is not safe practice to put a resident in the shower unattended. Staff are to be close to residents or monitoring residents for safety when in the tub room.</p> <p>An interview with RN Employee E6 on 6/7/2024, at 10:35 a.m. revealed that care plans are reviewed for assistance with showers or baths for residents who are on the shower schedule each day. It is not the practice of the nursing staff to leave residents unattended in the tub room. Staff is always close by or in the room assisting for resident safety in the tub room.</p> <p>An interview conducted with NA Employee E7 on 6/7/2024, at 10:40 a.m. revealed that residents' care plans are reviewed prior to the showers given so they have the correct number of staff to assist the resident safely. NA Employee E7 stated it is not the practice of the nursing staff to leave any resident unattended in the tub room for safety purposes. Staff is always close by or in the room assisting residents for safety purposes during baths or showers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON and Nursing Home administrator on 6/7/2024, at approximately 11:30 a.m. it was confirmed that per investigation, Resident R41 was placed in the tub room unattended by PTA Employee E1 and was left unattended in the bathtub. The resident slipped and fell in the tub resulting in a right shoulder fracture. Resident R41's care plan at the time of the fall on 4/10/2024, revealed a ADL self-care deficit and bathing required assist of one staff member with bathing and showering.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>		