

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/27/2024
NAME OF PROVIDER OR SUPPLIER  Sinking Spring Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3000 Windmill Road Sinking Spring, PA 19608	
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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45840</b></p> <p>Based on clinical record review, observation, policy review, and staff interview, it was determined that the facility failed to provide assistance with dining in a manner that promoted and maintained dignity for one resident on one of five nursing units. (Station 2, Resident 87) In addition, the facility failed to ensure that a call bell was answered in a timely manner for one of 35 sampled residents. (Resident 112)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 87 had diagnoses that included Alzheimer's disease, dysphagia (difficulty in swallowing), and protein-calorie malnutrition. Review of the Minimum Data Set (MDS) assessment, dated August 14, 2024, revealed that the resident had cognitive impairment and needed staff assistance with eating. Review of Resident 87's care plan revealed that staff was to provide total assistance with feeding, feed the resident slowly, and provide verbal cueing with meals. On August 25, 2024, from 12:16 p.m. through 12:35 p.m., nurse aide (NA) 1 was observed standing while assisting Resident 87 with lunch. On August 26, 2024, from 12:03 p.m. through 12:20 p.m., NA 1 was observed standing while assisting Resident 87 with lunch.</p> <p>Review of facility policy entitled, Call Lights, last reviewed April 3, 2024, revealed that staff were to respond to call lights and communication devices promptly.</p> <p>Clinical record review revealed that Resident 112 had diagnoses that included peripheral vascular disease (a disorder of the blood vessels that manage blood flow to parts of the body outside of the heart, most commonly affecting legs and feet), a muscle disorder, and a history of falling. Review of the MDS assessment dated [DATE], revealed the resident had physical limitations and required staff assistance for repositioning. Review of the nursing note dated August 19, 2024, revealed that Resident 112 was alert and was able to make herself understood. Review of the current care plan revealed the resident had physical limitations and that staff were to assist with repositioning frequently. Observation on August 26, 2024, from 12:50 p.m. through 1:10 p.m., revealed that the resident had her call bell activated. Staff were available at the nurses' station and in the hallways where the call bell could be clearly heard. Staff was observed looking at the activated call bell and walking by the resident's room, but no one answered the call bell and offered any assistance to Resident 112.</p> <p>In an interview on August 26, 2024, at 1:50 p.m., the Nursing Home Administrator and Director of Nursing stated that call lights were expected to be answered promptly.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395541
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F 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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<p>F 0584</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 a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17709</p> <p>Based on observation, it was determined that the facility failed to provide a safe, clean, and comfortable environment on three of five nursing units. (Medbridge, Station 2, and Arcadia)</p> <p>Findings include:</p> <p>Observations during the environmental tour on the Medbridge unit on August 25, 2024, at 12:30 p.m., revealed that in room [ROOM NUMBER], there was a large brown stain in the bathroom sink. There was also a black substance around and inside of the drain plug in the bathroom sink.</p> <p>Observation on August 25 and 26, 2024, in the morning and in the early afternoon at various times, revealed that there was a box outside of room [ROOM NUMBER] that contained a new toilet. In addition, observation on August 26, 2024, at 10:00 a.m. revealed there were two large garbage cans outside of room [ROOM NUMBER] that were uncovered. The one can was overflowing with trash. The box with the new toilet in it, and the two large garbage cans were cluttering this area near the nursing station and room [ROOM NUMBER].</p> <p>Observations during the environmental tour of Station 2 on August 25, 2024, at 9:25 a.m. through 1:50 p.m., revealed marred walls and chipped paint in rooms 71, 73, 77, 78, 83, 98, 104, 105, and 110. In room [ROOM NUMBER], bed A, there was a pervasive odor of urine and small black crawling insects observed on the nightstand. In room [ROOM NUMBER], bed B, the wall was gouged behind the bed. In room [ROOM NUMBER], bed A, the ceiling was bowing with an area of peeling tape. In room [ROOM NUMBER], the walls throughout the room were heavily covered in spackle and unpainted. In room [ROOM NUMBER], bed B, there was tube feed splattered on the base of the pump, floor, and wall. There was black streaks splattered on the wall under the sink. The rubber molding was peeling off by the bathroom, and used gloves were on the floor. In room [ROOM NUMBER], the wall was peeling above the backsplash. There were black streaks on the wall above the sink. The left-sided window curtain was stained.</p> <p>Observations during the environmental tour of Arcadia unit on August 25, 2024, at 11:00 a.m. through 1:50 p.m., revealed marred walls and chipped paint in rooms [ROOM NUMBERS]. In room [ROOM NUMBER], there were three holes in the wall facing the residents' beds. In room [ROOM NUMBER], there was a hole in the bathroom door.</p> <p>CFR 483.10(i)(1)(2) Safe/Clean/Comfortable/Homelike environment</p> <p>Previously cited 9/29/23 and 7/24/24</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1) Management.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45125</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan to meet each resident's needs identified in the comprehensive assessment for one of 35 sampled residents. (Resident 189)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 189 was admitted to the facility on [DATE], and had diagnoses that included anxiety and psychotic disorder with delusions. The Minimum Data Set (MDS) Care Area Assessment (CAA) summary dated May 9, 2024, noted that the resident's psychotropic drug use was to be addressed in the care plan. Review of the medication administration records revealed the resident was receiving both an antipsychotic and antidepressant at the time of the MDS CAA summary. There was no documented evidence that interventions to address Resident 189's psychotropic drug use were included in the current care plan.</p> <p>In an interview on August 27, 2024, at 10:25 a.m., the Administrator confirmed there was no documented evidence that Resident 189's care plan included interventions to address the use of psychotropic drugs.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709</b></p> <p>Based on clinical record review, and resident and staff interview, it was determined that the facility failed to provide services to improve activities of daily living (walking) for two of five sampled residents who required assistance with walking. (Residents 128, 157)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 128 had a diagnosis of disorder of the muscle. Review of nursing documentation revealed that she also had difficulty walking and had a history of repeated falls. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed that she was alert and oriented and utilized a walker. A review of the care plan revealed that she had a self care deficit with activities of daily living (ADL)'s due to physical limitations. There was an intervention for her to ambulate with a wheeled walker 20 feet with stand by assistance. Review of a physical discharge summary dated August 8, 2024, revealed that the therapist recommended a restorative ambulation program. The resident was to safely ambulate up to 30 feet using a walker and supervision/stand by assist to facilitate increased participation in functional activity. There was no documented evidence that the facility offered assistance the resident with walking consistently on a daily basis for the last 30 days. In an interview on August 25, 2024, at 12:20 p.m., the resident stated that she had not consistently received assistance with her walking from staff and that she felt unsteady at times if she walked by herself.</p> <p>Clinical record review revealed that Resident 157 had a diagnosis of muscle disorder and lumbago (dull aching pain in the back) with sciatica (pain of the sciatic nerve in the back radiating into the thigh). Review of nursing documentation revealed that the resident had difficulty walking. Review of the MDS assessment dated [DATE], revealed that the resident was alert and oriented. A review of the care plan revealed that the resident had a self care deficit with ADL's due to physical limitations. There was an intervention for the resident to walk with assistance of two people with a walker 5-10 feet. Review of a physical discharge summary dated June 10, 2024, revealed that the therapist recommended a restorative ambulation program. The resident was to ambulate 10-50 feet using a walker with minimal assistance. There was no documented evidence that the facility offered assistance to the resident with walking consistently on a daily basis for the last 30 days. In an interview on August 26, 2024, at 11:15 a.m., the resident stated that she had not consistently received assistance with her walking from staff on a daily basis.</p> <p>In an interview on August 27, 2024, at 11:33 a.m., the Administrator and Director of Nursing stated that there was no documented evidence that staff consistently assisted the resident with walking as per her plan of care and as recommended by a therapist.</p> <p>28 Pa.Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>45840</p> <p>Based on observation and interview, it was determined that the facility failed to post accurate and current nurse staffing information.</p> <p>Findings include:</p> <p>Observations during tours of the facility conducted on August 25, 2024, at 9:05 a.m., and August 26, 2024, at 9:13 a.m., revealed that staffing information posted in the lobby was dated for August 23, 2024.</p> <p>In an interview on August 27, 2024, at 11:24 a.m., the Nursing Home Administrator confirmed that incorrect staffing information was posted.</p> <p>28 Pa. Code 201.18(b)(3) Management.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>45125</p> <p>Based on facility documentation, resident interview, results of a test tray audit, and staff interview, it was determined that the facility failed to provide food that was palatable and at an appetizing temperature on one of five nursing units. (Medbridge)</p> <p>Findings include:</p> <p>Review of Dining Council Minutes from August 14, 2024, revealed that residents had stated that their food gets served cold. In a group interview on August 26, 2024, at 10:30 a.m., Residents 59, 149, and 168 revealed that it is an ongoing problem that hot food is frequently served cold.</p> <p>Review of facility documentation entitled, Food and Nutrition Services Test Tray Evaluation, the hot main entree, starch and vegetable should be greater than 140 degrees Fahrenheit (F) at point of service to the resident.</p> <p>Results of a test tray audit conducted on August 26, 2024, at 12:15 p.m., after the last resident meal tray was served from the dining cart, revealed a smothered pork chop was served at a temperature of 112.6 degrees F and the roast potatoes at a temperature of 108 degrees F. Both food items were cool to taste. The Director of Dining Services had sampled the food items and confirmed they were cool to taste.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709</b></p> <p>Based on clinical record review, observation and staff interview, it was determined that the facility failed to ensure that residents were served preferred and selected food items on their meal trays for two of 35 sampled residents. (Resident 199, 202)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 199 had a diagnosis of an adjustment disorder with mixed anxiety and depressed mood. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was alert and oriented. A review of the care plan revealed that the resident was at nutritional risk due to a history of weight loss. There was an intervention for staff to honor food preferences within the meal plan. In an interview on August 25, 2024, at 10:30 a.m., the resident stated that frequently, he did not receive food and drink items that he had selected for his meals. Review of the current menu revealed that the lunch meal for August 26, 2024, was cheese lasagna and garlic bread. On August 26, 2024, at 12:15 p.m., the resident was served his meal. Review of his meal tray ticket revealed that he preferred to receive two cartons of iced tea, two slices of garlic bread and two packets of pepper seasoning. The resident had not received any of these preferred items. At this time, the resident stated this happens all the time. and that he really enjoyed drinking iced tea.</p> <p>Clinical record review revealed that Resident 202 had diagnoses that included folate (B-vitamin) deficiency anemia. The MDS assessment dated [DATE], indicated that the resident was alert and oriented. A review of the care plan revealed that the resident was at nutritional risk due to the diagnosis of folate deficient anemia. There was an intervention for staff to honor food preferences within the meal plan. Review of the current menu revealed that the lunch meal for August 25, 2024, was country fried steak, green beans and mashed potatoes. The alternate meal for lunch was chicken alfredo penne and green beans. Observation on August 25, 2024, at 1:12 p.m., revealed the resident was served her meal. She received the alternate meal of chicken alfredo penne and she did not receive any green beans. A review of her meal tray ticket revealed that she was to receive the country fried steak, green beans and mashed potatoes, not the alternate meal. At this time, she stated that she did not want the alternate meal and had selected the main meal. She further stated that she often did not receive the meals and food that she preferred or selected.</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>45125</p> <p>Based on facility policy review and observation, it was determined that the facility failed to properly store food and maintain sanitary conditions on two of four unit pantries. (Station 2 and Arcadia)</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Food Brought in for Residents, last reviewed April 3, 2024, revealed that staff were to label food items requiring refrigeration with the resident's name and date the food was brought in and the food would be discarded after three days by staff upon notification to the resident.</p> <p>Observation of the Arcadia unit pantry on August 25, 2024, at 10:32 a.m., revealed a sign on the refrigerator door that it was for resident food only and that foods must be discarded after three days. In the freezer, there was a layer of sticky, dried liquid with two strands of hair. There were three containers of raspberry orange sherbet and frozen grape concentrate that were not labeled with a resident's name or date. In the refrigerator, there was a container of dished applesauce dated August 21, 2024, a bottle of milk with an opening date of August 18, 2024, but with a use-by date of August 6, 2024, that did not have a name on it, and an opened bottle of juice with an illegible opening date and a best-by date of August 4, 2024. There was an opened bottle of seltzer water and a Danish that were not labeled with a resident name or date. Inside the refrigerator, both door shelves had dried liquid debris on them with strands of hair and there was liquid debris on the bottom under the drawers.</p> <p>Observation of the Station 2 unit pantry on August 26, 2024, at 10:33 a.m., revealed a sign on the refrigerator door that it was for resident food only and that foods must be discarded after three days. In the freezer, there was a half eaten whoopie pie that did not have a name or date on it. In the refrigerator, there was a sandwich for a resident that was dated August 16, 2024, and a bun and juice wrapped together with no date on it. There was a package of string cheese, opened bottles of fruit punch, lemonade, and juice, two plastic bags that had containers of a white liquid, fruit salad, margarine, French fries, and a sandwich that were not labeled with a resident name or date.</p> <p>CFR 483.60(i) Food Safety Requirement</p> <p>Previously cited 9/29/23</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(e)(2.1) Management.</p>		

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<p>F 0814</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>45125</p> <p>Based on observation, it was determined that the facility failed to dispose of trash and refuse properly.</p> <p>Findings include:</p> <p>Observation of the trash compactor on August 25, 2024, at 10:30 a.m., revealed there was garbage and debris, including used gloves, plastic food bags, plastic straws, and a gauze roll on the ground around the compactor. There was a full garbage bag stuck between the compactor and the ground. The top lid was wide open on the garbage dumpster that was full of trash bags. There was a walker next to the dumpster.</p> <p>28 Pa. Code 201.18(b)(3)Management.</p>		