

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Shenandoah Senior Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. Washington St Shenandoah, PA 17976	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944</p> <p>Based on observations and resident and staff interviews it was determined the facility failed to accommodate residents' need and preference for access to the call bell system in order to request staff assistance for one resident (Resident 79).</p> <p>Findings include:</p> <p>A review of Resident 79's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (also known as an ischemic stroke, is the pathologic process that results in an area of necrotic tissue) with hemiplegia (is a symptom that involves one-sided paralysis. Hemiplegia affects either the right or left side of your body) and hemiparesis (is one-sided muscle weakness and occurs due to disruptions in the brain, spinal cord or the nerves that connect to the affected muscles) to the right dominant side, dysphagia (difficulty swallowing), and muscle weakness.</p> <p>A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 26, 2024, revealed the resident was dependent on staff for all care and ADL's (activities of daily living).</p> <p>During an observation of Resident 79, on September 12, 2024, at 10:00 a.m., the resident was sleeping in his bed. The resident's call bell was observed on the floor and not within the resident's reach.</p> <p>Further observation at 10:30 a.m., revealed Resident 79's call bell remained on the floor.</p> <p>During an interview, at the time of the observation, with Employee 1, a Licensed Practical Nurse (LPN), confirmed the resident's call bell was not in his reach.</p> <p>Interview with the Director of Nursing on September 12, 2024, at 1:35 p.m., the inability to reach the call for Resident 79 was discussed and the DON confirmed residents' call bells should be within reach to alert staff of the need for assistance.</p> <p>28 Pa Code 211.12 (c)(d)(3)(5) Nursing services</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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on observation, a review of clinical records, a review of nurse staffing, and interviews with staff and residents, it was determined the facility failed to provide sufficient nursing staff to provide timely and quality care for residents that sustained falls, for three residents out of 20 sampled (Residents 7, 70, and 90) and failed to provide timely care expressed by residents during a resident group interview (Residents 1, 35, 52, 65, and 71).</p> <p>Findings included:</p> <p>The facility failed to provide sufficient supervision and implement effective fall prevention interventions for two residents at high risk for falls, Resident 7 and Resident 70, both of whom experienced repeated falls despite being identified as high fall risks.</p> <p>A review of Resident 7's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included dementia and severe cognitive impairment. Resident 7 has a documented history of falls from her Broda chair, often accompanied by agitation and behaviors. Despite various care plan interventions (e.g., chair alarms, non-skid footwear), the resident continued to experience falls, including incidents on April 5, April 18, April 22, and May 22, 2024. Staff repeatedly documented the resident's agitated behaviors and attempts to get out of her chair unassisted, yet adequate supervision and effective fall interventions were not sustained.</p> <p>A clinical record review revealed Resident 70 was admitted to the facility on [DATE], with diagnoses that included dementia and a documented fall history. Despite various care plan interventions to mitigate Resident 70's risk of falling and protect him from injury (e.g., ensuring his bed is in the lowest position, bilateral floor mats, a bed alarm, and ensuring his call bell is within reach), the resident continued to experience falls, including incidents on February 24, March 2, March 29, and June 2, 2024.</p> <p>A clinical record review revealed Resident 90 was admitted to the facility on [DATE], with diagnoses that included orthopedic aftercare and with inflammation and infection to an internal right hip prosthesis (hip replacement). A review of an admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 4, 2024, revealed that Resident 90 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</p> <p>During an interview on September 10, 2024, at 12:05 PM, Resident 90 reported experiencing pain and stated that he had been waiting to be helped into bed to rest since 11:00 AM. He explained that he is new to the facility and has been experiencing long wait times for care. He mentioned that he typically waits 30 minutes to an hour, and last night, he waited for over an hour. Resident 90 clarified that he does not blame the staff, as they are doing their best, but there aren't enough staff members to assist the residents promptly. He expressed frustration with the long wait times for care.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on September 10, 2024, at 12:18 PM, Employee 6, Nurse Aide, confirmed that Resident 90 had been waiting for about 45 minutes to be assisted into bed. She explained that she is the only staff member in the area at the time and needs assistance to safely transfer him. Employee 6 emphasized that she is doing her best, but there are not enough staff to meet the residents' needs in a timely manner. She also noted that there are about 27 residents in the hallway and only two staff members available to care for them. While she is busy with resident care now, she mentioned the evening shift often faces even greater staffing shortages.</p> <p>During an interview on September 10, 2024, at 12:20 PM, Employee 5, Nurse Aide, reported that Resident 90 had requested to be transferred into bed around 11:30 AM. She explained that it requires two staff members to transfer him, but no one was available to help her at that moment because staff were busy serving meals.</p> <p>At 12:31 PM on September 10, 2024, Employees 5 and 6 were observed entering Resident 90's room to assist him into bed.</p> <p>During a resident group interview, with alert and oriented residents, on September 11, 2024, at 10:00 AM, Residents 1, 35, 52, 65, and 71 indicated the lack of nursing staff has negatively affected the care services they receive at the facility.</p> <p>During the resident group interview, Resident 1 indicated that he often waits 30 minutes to an hour for care, and the wait times are the longest on the evening and night shifts. He explained that when the facility uses agency staff because of staff shortages, the care is not any better. Resident 1 indicated that facility staff will give him a bed bath instead of a shower because they are low on staffing. He indicated that a few times this week he was not offered a snack because the nurse aides were busy providing care to other residents.</p> <p>During the resident group interview, Resident 35 indicated that she is independent and does not need to rely on staff for assistance with care. However, she indicated that two or three times this week there were not enough staff to pass out evening snacks. She explained that when the facility uses agency staff, they do not know that snacks need to be offered to residents.</p> <p>During the resident group interview, Resident 52 indicated that she sometimes waits 30 minutes or longer for care after ringing her call bell for assistance. She indicated that sometimes there is only one nurse aide assigned to her hallway and that the one staff is not able to take care of all the residents needs.</p> <p>During the resident group interview, Resident 65 indicated that he waits 30 minutes on the evening and night shift for staff to respond to his call bell after he rings for assistance.</p> <p>During the resident group interview, Resident 71 expressed concerns about staffing levels at the facility, stating that there is not enough staff. She explained that staff members never ask or remind her about taking her scheduled shower. Resident 71 reported that if she does not inform the staff that it is her shower day, she missed her shower for the week, resulting in a two-week gap between showers.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's nurse staffing from September 5, 2024, to September 11, 2024, revealed that the facility failed to meet the state's minimum requirement for direct care hours per patient on all seven days. The required direct care hours represent the minimum amount of care each resident must receive daily, which may increase based on individual resident needs. The facility provided an average of 2.72 hours of care per resident per day, falling short of the state-mandated minimum of 3.2 hours.</p> <p>A review of the facility's nurse staffing from September 5, 2024, to September 11, 2024, revealed the facility failed to meet the required minimum state ratio for nurse aides on 9 of the 21 shifts reviewed. The facility failed to meet the required minimum state ratio for licensed practical nurses on 6 of the 21 shifts reviewed. The facility failed to meet the state minimum required nursing staff direct care hours per day for each resident on 7 out of 7 days reviewed.</p> <p>During an interview on September 13, 2024, at approximately 10:30 AM, the Nursing Home Administrator (NHA) confirmed that the facility failed to meet the state minimum requirements for nurse aides, licensed practical nurses, and nurse staff direct care hours for residents per day. The NHA confirmed that it is the facility's responsibility to provide sufficient nursing staff to provide timely and quality care to each resident. Furthermore, the NHA confirmed the facility is responsible to ensure that there is sufficient nurse staffing to provide adequate supervision to residents who are at risk of falling, to protect residents from injury, and mitigate residents' risk of falling.</p> <p>Refer F656 F689</p> <p>28 Pa. Code 201.18 (b)(1)(3)(e)(1)(2)(3)(6) Management.</p> <p>28 Pa. Code 201.29 (a) Resident rights.</p> <p>28 Pa. Code 211.12 (c)(d)(4)(5)(f.1)(4)(i)(2) Nursing services.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>39235</p> <p>Based on review of select facility policy and controlled drug records, observation, and staff interview, it was determined the facility failed to implement pharmacy procedures for the reconciliation of controlled drugs on two of three medication carts reviewed (A, and C hall).</p> <p>Finding include:</p> <p>A review of facility policy entitled Controlled Substances last reviewed by the facility on June 21, 2024, states that nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. Any discrepancies in the controlled substance count are documented and reported to the director of nursing (DON) services immediately.</p> <p>An observation of the medication pass on September 10, 2024, at approximately 11:40 AM, revealed Employee 1 Licensed Practical Nurse (LPN), working the Medication Cart C. A review of a document entitled Shift Change Narcotic Audit, identified by Employee 1 (LPN), as the change of shift controlled count sheet for September 2024, for the C medication cart revealed that the on-coming nurse and/or off-going nurse failed to sign the sheets during shift change on the following dates to verify completion of the task to count the controlled drugs in the respective medication cart on September 4, and 5, 2024.</p> <p>Interview with Employee 1 (LPN), on September 10, 2024, at approximately 11:42 AM, confirmed the observation and acknowledged the licensed nurses are expected sign the count verification at change of shift.</p> <p>An observation of the medication pass on September 11, 2024, at approximately 9:40 AM, revealed Employee 2 Licensed Practical Nurse (LPN), working the Medication Cart A. A review of a document entitled Shift Change Narcotic Audit, identified by Employee 2 (LPN), as the change of shift controlled count sheet for September 2024, for the A medication cart revealed that the on-coming nurse and/or off-going nurse failed to sign the sheets during shift change on the following date to verify completion of the task to count the controlled drugs in the respective medication cart on September 3, 2024.</p> <p>Interview with Employee 2 (LPN), on September 11, 2024, at approximately 9:50 AM, confirmed the observation and acknowledged the licensed nurses are expected sign the count verification at change of shift.</p> <p>Interview with the Director of Nursing (DON) on September 12, 2024, at approximately 9:40 AM, confirmed that it is her expectation that nursing staff signs the Control Substance logs, at change of shift to demonstrate that they completed the counts of the controlled drugs to timely identify any discrepancies.</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy services</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>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on clinical record review, observations, and staff interview, it was determined the facility failed to maintain infection control practices to prevent potential spread of infection for two out of 20 residents sampled (Resident 77 and 83) and failed to offer and/or provide SARS-CoV-2 (COVID-19) immunization, unless the immunization was medically contraindicated or the resident has already been immunized, to one of five residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>A review of facility policy titled Coronavirus Disease (COVID-19)-Infection Prevention and Control Measures, last reviewed by the facility on June 21, 2024, revealed the facility follows infection prevention and control practices recommended by the Centers for Disease Control and Prevention to prevent the transmission of COVID-19 within the facility.</p> <p>A review of the CDC 's Use of an Additional Updated 2023-2024 COVID-19 Vaccine Dose for Adults Aged greater than or equal to [AGE] years: Recommendations of the Advisory Committee on Immunization Practices-United States, 2024, revealed according to the Advisory Committee on Immunization Practices (ACIP) recommendations as of February 28, 2024, all persons aged [AGE] years and older should receive one additional dose of an updated (2023-2024 Formula) COVID-19 vaccine (Moderna, Novavax, or Pfizer-BioNTech). This dose should be given at least four months after their previous updated dose to enhance immunity and reduce the risk of severe COVID-19-associated illness.</p> <p>A review of the CDC's Testing and Management Considerations for Nursing Home Residents with Acute Respiratory Illness Symptoms when SARS-CoV-2 (COVID-19) and Influenza Viruses are Co-circulating, lasted reviewed November 14, 2023, revealed that residents confirmed to have SARS-CoV-2 infection should be placed in a single room, if available, or housed with other residents with only SARS-CoV-2 infection.</p> <p>A review of the COVID-19 Infection Control and Outbreak Response Toolkit for Long Term Care Published July 2023 by the Pennsylvania Department of Health indicates;</p> <p>Dedicating an area within the facility to cohort residents on isolation for confirmed COVID-19 during their infectious period is best practice for decreasing the likelihood of transmission.</p> <p>Components of a COVID-19 Care Unit ideally include the following:</p> <p>Physical separation from other rooms and spaces where residents are not confirmed with COVID-19;</p> <p>Single-person room(s) with designated bathroom(s);</p> <p>Place a resident with suspected or confirmed COVID-19 in a single- person room. The door should be kept closed, if safe to do so. The resident should have a dedicated bathroom.</p> <p>(continued on next page)</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>If limited single rooms are available, or if numerous residents are simultaneously identified to have symptoms concerning for COVID-19, residents may remain in their current location until cause of symptoms is determined.</p> <p>If cohorting, only residents with the same pathogen should be housed in the same room. Multidrug-resistant organism (MDRO) colonization or infection status, and/or presence of other communicable disease should also be taken into consideration during the cohorting process.</p> <p>A clinical record review revealed Resident 77 was admitted to the facility on [DATE], with diagnoses that included aftercare following digestive system surgery.</p> <p>A clinical record review revealed Resident 83 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities).</p> <p>A clinical record review revealed Resident 77 and Resident 83 shared resident room Blue Wing 07.</p> <p>Facility infection control tracking records indicate that Resident 77 tested positive for SARS-CoV-2 (COVID-19) on September 3, 2024.</p> <p>A clinical record review failed to find documented evidence that the facility attempted to isolate Resident 77 in a single room.</p> <p>A clinical record review failed to find documented evidence that the facility provided Resident 83 or Resident 83's representative information regarding the risks of sharing a room with a resident that tested positive for SARS-CoV-2 (COVID-19), including current CDC recommendations. There was no documented evidence in the clinical record the facility provided Resident 83 or Resident 83's representative with an opportunity to make an informed decision to change rooms.</p> <p>Facility infection control tracking records indicate that Resident 83 tested positive for SARS-CoV-2 (COVID-19) on September 5, 2024.</p> <p>During an interview on September 13, 2024, at approximately 9:30 AM, the Director of Nursing (DON) was unable to provide evidence the facility attempted to isolate Resident 77 in a single resident room or in a room with only other residents that tested positive for SARS-CoV-2 (COVID-19). The DON confirmed there was no documented evidence the facility provided Resident 83 or Resident 83's representative with an opportunity to make an informed decision to change rooms.</p> <p>A review of the DON's Nursing Home Infection Preventionist Training credentials revealed that she was not certified as an infection preventionist until August 27, 2024.</p> <p>During an interview on September 13, 2024, at approximately 10:30 AM, the Nursing Home Administrator (NHA) confirmed that the facility did not currently have an infection preventionist. The NHA explained that the Director of Nursing (DON) has been covering the duties of the infection preventionist since July 18, 2024. The NHA confirmed that the DON was not certified as an infection preventionist until August 27, 2024.</p> <p>(continued on next page)</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>A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities).</p> <p>A clinical record review revealed no evidence that Resident 2 or Resident 2's representative received education regarding the benefits and potential side effects of SARS-CoV-2 (COVID-19) immunization. The clinical record did not contain evidence that Resident 2 was offered SARS-CoV-2 (COVID-19) immunization since May 19, 2022. Resident 2's clinical record did not indicate that receiving SARS-CoV-2 (COVID-19) immunization is medically contraindicated.</p> <p>During an interview on September 13, 2024, at approximately 9:30 AM, the Director of Nursing (DON) was unable to provide evidence Resident 2 or Resident 2's representative received education regarding the benefits and potential side effects of SARS-CoV-2 (COVID-19) immunization, evidence Resident 2 was offered SARS-CoV-2 (COVID-19) immunization since May 19, 2022, or evidence that SARS-CoV-2 (COVID-19) immunization is medically contraindicated for Resident 2. The DON confirmed that the facility is responsible for ensuring residents/resident representatives are afforded the opportunity to make informed decisions regarding SARS-CoV-2 (COVID-19) immunization.</p> <p>Refer F882</p> <p>28 Pa. Code 211.10(a)(d) Resident care policies</p> <p>28 Pa code 211.12 (c)(d)(1)(5) Nursing Services</p>		