

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER Julia Pound Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1155 Indian Springs Road Indiana, PA 15701	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46994</p> <p>Based on clinical record reviews, as well as staff interviews, it was determined that the facility failed to follow physician's orders for one of five residents reviewed (Resident 3).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 3, dated November 14, 2024, revealed that the resident was sometimes understood, could sometimes understand others, and had diagnoses that included diabetes and dementia.</p> <p>Physician's orders for Resident 3, dated November 1, 2024, included that the resident receive 5 milligrams (mg) of olanzapine (used to treat the symptoms of schizophrenia) at bedtime. Review of Resident 3's Medication Administration Record (MAR), dated November 2024, revealed that there was no documented evidence that the resident received this medication on November 11, 2024, or on November 29, 2024.</p> <p>Physician's orders for Resident 3, dated November 1, 2024, included that the resident receive two 325 mg tablets of Tylenol at bedtime. Review of the resident's MAR, dated November 2024 and December 2024, revealed that there was no documented evidence that the resident received this medication on November 17, 2024, or on December 13, 2024, as ordered.</p> <p>Physician's orders for Resident 3, dated November 1, 2024, included that the resident receive 250 mg probiotic (supplements intended to maintain or improve the good bacteria in the body) capsule at bedtime. Review of the resident's MAR, dated November 2024 and December 2024, revealed that there was no documented evidence that the resident received this medication on November 17, 2024, or on December 13, 2024, as ordered.</p> <p>Physician's orders for Resident 3, dated November 1, 2024, included that the resident receive 15 mg tablets of buspirone (antianxiety medication) twice a day. Review of the resident's MAR, dated November 2024 and December 2024, revealed that there was no documented evidence that the resident received the nighttime dose of this medication on November 17, 2024, or on December 13, 2024, as ordered.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physician's orders for Resident 3, dated November 1, 2024, included that the resident receive 30 mg tablets of duloxetine (used to treat depression and anxiety) twice a day. Review of the resident's MAR, dated November 2024 and December 2024, revealed that there was no documented evidence that the resident received the nighttime dose of this medication on November 17, 2024, or on December 13, 2024, as ordered.</p> <p>Physician's orders for Resident 3, dated November 1, 2024, included that the resident receive 15 mg of mirtazapine (antidepressant) at bedtime. Review of the resident's MAR, dated November 2024 and December 2024, revealed that there was no documented evidence that the resident received this medication on November 17, 2024, or on December 13, 2024, as ordered.</p> <p>Physician's orders for Resident 3, dated November 1, 2024, included that the resident receive 20 mg of rosuvastatin (used to treat high cholesterol) once a day. Review of the resident's MAR, dated November 2024 and December 2024, revealed that there was no documented evidence that the resident received this medication on November 17, 2024, or on December 13, 2024, as ordered.</p> <p>Physician's orders for Resident 3, dated November 3, 2024, included that the resident receive two 10 milliequivalent (mEq) capsules of potassium chloride (medication used to prevent or to treat low blood levels of potassium) twice a day. Review of the resident's MAR, dated November 2024 and December 2024, revealed that there was no documented evidence that the resident received the nighttime dose of this medication on November 17, 2024, or on December 13, 2024, as ordered.</p> <p>Interview with the Director of Nursing on December 16, 2024, at 4:20 p.m. confirmed that there was no documented evidence that the resident received the above-mentioned medications as ordered.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>46994</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that physician's orders were followed, resulting in significant medication errors for one of six residents reviewed (Resident 3).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 3, dated November 14, 2024, revealed that the resident was sometimes understood, could sometimes understand others, and had diagnosis which included diabetes and dementia.</p> <p>Physician's orders for Resident 3, dated November 1, 2024, included for the resident to have her blood glucose (amount of sugar in the blood) level checked before meals and at bedtime, receive 25 units of Lantus Solostar (long-acting insulin used to treat high blood sugar) twice a day, and 6 units of insulin lispro (fast acting insulin used to treat high blood sugar) three times a day. Physician's orders, dated November 1, 2024, also included for the resident to receive 2 units of insulin lispro if her blood sugar was between 150 milligrams per deciliter (mg/dL) and 199 mg/dl; 4 units of insulin lispro if her blood sugar was between 200 mg/dL and 249 mg/dL; 6 units of insulin lispro if her blood sugar was between 250 mg/dL and 299 mg/dL; 8 units of insulin lispro if her blood sugar was between 300 mg/dL and 349 mg/dL; 10 units of insulin lispro if her blood sugar was between 350 mg/dL and 399 mg/dL; and 12 units of insulin lispro if her blood sugar was between 400 mg/dL and 450 mg/dL.</p> <p>Review of the Medication Administration Record (MAR) for Resident 3, dated November 2024 and December 2024, revealed no documented evidence that the resident received 25 units of Lantus Solostar insulin at bedtime as ordered on December 13. There was no documented evidence that the resident received 6 units of insulin lispro at breakfast time as ordered on November 13, 17, 21, 22, and 28, and December 12; no documented evidence that the resident received 6 units of insulin lispro at lunch time as ordered on November 17, 21, 22, and 28, and December 4, 10, and 12; and no documented evidence that the resident received 6 units of insulin lispro at suppertime as ordered on November 28 and December 10. Review of the MAR revealed that there was no documented evidence that the resident's blood sugar was checked before breakfast on November 13, 21, and 28 and December 12, and at bedtime on December 13, and no sliding scale insulin coverage was provided. Review of the MAR revealed that the resident's blood glucose before lunch on November 17 was 172 mg/dL, requiring 2 units of insulin lispro; however, there was no documented evidence that it was administered to the resident. The resident's blood glucose before lunch on November 28 was 164 mg/dL, requiring 2 units of insulin lispro; however, there was no documented evidence that it was administered to the resident. The resident's blood glucose before supper on November 28 was 361 mg/dL, requiring 10 units of insulin lispro; however, there was no documented evidence that it was administered to the resident. The resident's blood glucose before supper on December 10 was 244 mg/dL, requiring 4 units of insulin lispro; however, there was no documented evidence that it was administered to the resident.</p> <p>Interview with the Director of Nursing on December 16, 2024, at 4:20 p.m. confirmed that there was no documented evidence that the resident received blood glucose checks and insulin as ordered on the above-mentioned dates and times.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing 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>46994</p> <p>Based on review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of five residents reviewed (Resident 3).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 3, dated November 14, 2024, revealed that the resident was sometimes understood, could sometimes understand others, and had a diagnosis which included diabetes and dementia.</p> <p>Review of nurse aide documentation, dated December 3, 2024, revealed that the resident ate 100 percent of her lunch meal.</p> <p>Review of a grievance investigation related to Resident 3, dated December 3, 2024, revealed that Resident 3's lunch tray was removed from her room at 3:45 p.m. by the Director of Nursing, and the resident did not eat anything on that tray.</p> <p>Interview with the Director of Nursing on December 16, 2024, at 4:20 p.m. confirmed that nurse aide documentation of the resident's lunch meal on December 3, 2024, was documented incorrectly.</p> <p>28 Pa. Code 211.5(f) Clinical Records</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		