

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 06/05/2025
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 complete accurate comprehensive Minimum Data Set assessments for four of 33 residents reviewed (Residents 12, 18, 72, 81).</p> <p>Findings include:</p> <p>The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of residents' abilities and care needs), dated October 2024, indicated that Section B was to be completed for each resident to document the resident's ability to understand and communicate with others. Section B0700 was to be coded zero (0) if the resident was understood by others, one (1) for usually understood, two (2) for sometimes understood, and three (3) for rarely/never understood. Section C was to be completed for each resident to identify his/her cognitive status. Section C0100 was to be coded No (0) or Yes (1) depending on whether a Brief Interview for Mental Status (BIMS) should be attempted with the resident and coded in Sections C0200 through C0500. The instructions for determining if a BIMS interview should be attempted indicated that if the resident was at least sometimes understood (verbally or in writing) then the BIMS interview was to be attempted with the resident. If the resident was rarely/never understood, then the BIMS interview was not to be attempted, and a Staff Assessment of Mental Status was to be completed instead and coded in Sections C0600 through C1000.</p> <p>A significant MDS assessment for Resident 12, dated March 19, 2025, revealed that Section B0700 was coded two (2), indicating that the resident was sometimes understood by others. However, Section C0100 was coded (0) No, indicating that the resident was rarely/never understood by others, and Sections C0200 through C0500 (the BIMS interview) were not completed.</p> <p>A quarterly MDS assessment for Resident 18, dated April 3, 2025, revealed that Section B0700 was coded zero (0), indicating that the resident was understood by others. However, Section C0100 was coded (0) No, indicating that the resident was rarely/never understood by others, and Sections C0200 through C0500 (the BIMS interview) were not completed.</p> <p>A quarterly MDS assessment for Resident 72, dated March 19, 2025, revealed that Section B0700 was coded two (2), indicating that the resident was sometimes understood by others. However, Section C0100 was coded (0) No, indicating that the resident was rarely/never understood by others, and Sections C0200 through C0500 (the BIMS interview) were not completed.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Social Worker on June 5, 2025, at 9:54 a.m. confirmed that Section C0100 was coded inaccurately on the above MDS assessments for Residents 12, 18, and 72.</p> <p>The RAI User's Manual, dated October 2024, indicated that the intent of Section A was to record the discharge status of the resident. Section A2105 was to be coded with the location of the resident's discharge.</p> <p>A nursing note for Resident 81, dated March 12, 2025, indicated that the resident was transferred to the local hospital where he was admitted for acute care. However, a discharge tracking MDS, dated [DATE], indicated that Resident 81 was discharged to a nursing home.</p> <p>An interview with the Registered Nurse Assessment Coordinator (registered nurse responsible for accurate reporting information) on June 5, 2025 at 10:44 a.m. confirmed that Resident 81 was discharged to the hospital and not to a nursing home. She confirmed that she entered the wrong discharge location on Resident 81's discharge tracking MDS.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</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>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for two of 33 residents reviewed (Residents 27, 60).</p> <p>Findings include:</p> <p>A facility policy regarding care plans, dated March 12, 2025, indicated that the facility will comprehensively evaluate and re-evaluate a resident's need for service and develop a plan to promote their highest practicable level of functioning. The care plan will be reviewed and evaluated for intervention effectiveness and updated electronically as needed.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 27, dated May 20, 2025, indicated that the resident was cognitively intact, required assistance with care needs, had limited range of motion (the full movement potential of a joint) to her lower extremities on both sides, and had diagnoses that included muscular dystrophy (disease that causes progressive weakness and loss of muscle mass). A restorative care plan for the resident, dated February 25, 2025, included a program for restorative splint/brace assistance for bilateral PRAFO boots (used to help manage many ankle/foot abnormalities) with kickstand to the outside of the boots at all times as the resident tolerates with instructions to remove for hygiene, skin checks, and range of motion.</p> <p>Observations of Resident 27 on June 3, 2025, at 2:17 p.m.; June 4, 2025, at 12:52 p.m.; and June 5, 2025, at 9:06 a.m. revealed that the resident did not have PRAFO boots applied to her bilateral lower extremities. Interview with the resident on June 5, 2025, at 9:06 a.m. revealed that she stopped wearing those boots a long time ago because they hurt her feet and indicated that therapy had taken them away because she was not wearing them.</p> <p>Interview with the therapy manager on June 5, 2025, at 10:05 a.m. confirmed that Resident 27's PRAFO boots were discontinued about a month or two ago due to the resident declining to wear them.</p> <p>Interview with the Assistant Director of Nursing on June 5, 2025, at 12:01 p.m. confirmed that Resident 27's restorative care plan should have been revised to reflect that the resident was no longer using the PRAFO boots.</p> <p>A quarterly MDS assessment for Resident 60, dated May 12, 2025, indicated that the resident was cognitively intact, required maximum assistance from staff for care, and was always incontinent of urine. The resident's care plan, dated May 2, 2025, indicated that the resident had frequent urinary tract infections and that staff were to assess urinary output, record the amount, type, color, and odor.</p> <p>A nursing note for Resident 60, dated April 30, 2025, revealed that the resident no longer had an indwelling urinary catheter and that she was now incontinent of urine.</p> <p>There was no documented evidence that Resident 60's care plan was updated with revised and/or new urinary incontinence interventions after her indwelling urinary catheter was removed.</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>Interview with the Director of Nursing on June 5, 2025, at 12:30 p.m. confirmed that Residents 60's care plan should not have indicated that the resident's urine output was to be monitored or recorded.</p> <p>28 Pa. Code 211.12(d)(5) 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>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for two of 33 residents reviewed (Resident 42, 72).</p> <p>Findings include:</p> <p>A facility policy for medication administration, dated March 12, 2025, indicated that the individual who administers the medication records the administration on the resident's Medication Administration Record (MAR) directly after the medication is given.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 42, dated May 15, 2025, indicated that the resident was cognitively intact, required assistance with care needs, and was taking an opioid medication (medications with the potential to be abused used to treat pain).</p> <p>Physician's orders for Resident 42, dated October 23, 2024, included an order for the resident to receive two 50 milligrams (mg) tablets of Tramadol (a narcotic pain medication) to equal 100 mg every eight hours as needed for moderate to severe pain.</p> <p>Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 42, dated April and May 2025, revealed that two 50 mg tablets of Tramadol were signed out on April 14 at 5:00 p.m.; May 10 at 5:15 a.m. and 4:20 p.m.; May 21 at 6:50 p.m.; May 25 at 1:50 a.m.; and May 31 at 12:19 a.m. However, there was no documented evidence in Resident 42's clinical record, including the MAR, that the signed-out doses of Tramadol were administered to the resident on the above-mentioned dates and times.</p> <p>Interview with the Assistant Director of Nursing on June 5, 2025, at 10:34 a.m. confirmed that there was no documented evidence in Resident 42's clinical record to indicate that the signed-out doses of Tramadol were administered to the resident on the above-mentioned dates and times.</p> <p>A quarterly MDS assessment for Resident 72, dated March 19, 2025, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included dementia and chronic pain syndrome.</p> <p>Physician's orders for Resident 72, dated February 25, 2025, included an order for the resident to receive 50 milligrams (mg) of Tramadol (a controlled pain medication) every 12 hours as needed for moderate pain.</p> <p>A review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 72, dated April, May, and June 2025, that one 50 mg tablet of Tramadol was signed out for administration to the resident on April 10 at 11:32 p.m.; April 18 at 11:00 p.m.; May 9 at 5:00 a.m.; May 28 at 11:15 p.m.; May 31, at 11:40 p.m.; and June 1 at 12:05 a.m. However, there was no documented evidence in the resident's clinical record to indicate that the signed-out tablets of Oxycodone were administered to the resident on the above-mentioned dates and times.</p> <p>(continued on next page)</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>An interview with the Assistant Director of Nursing on June 5, 2025, at 12:21 p.m. confirmed that there was no documented evidence that staff administered the controlled drugs to Resident 72 on the dates mentioned above.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</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>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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to properly date medications after they were opened in two of three medication carts reviewed (Highlands 1 and Highlands 2), and failed to discard expired medical supplies in one of two medication rooms reviewed (Highlands).</p> <p>Findings include:</p> <p>The facility's policy regarding medication storage, dated [DATE], revealed that the facility would store medications and biologicals safely, securely and properly. In addition, when the original seal of the manufacturer's container is initially broken, a date opened and expired date sticker shall be placed on the container.</p> <p>Observations in Highlands medication cart 2 on [DATE], at 9:36 a.m. revealed that there were two containers of 1 percent diclofenac sodium (pain reliever) topical gel, one container of 0.1 percent triamcinolone (steroid used to decrease inflammation) cream, and two containers of 12 percent ammonium lactate (treats dry itchy skin) topical cream in use with the seal broken, that did not have the date opened and date expired sticker on them.</p> <p>Observations in the Highlands 100-200 hall medication room black storage box on [DATE], at 9:50 a.m. revealed that there was one unsealed 10 milliliter (ml) normal saline flush (a syringe filled with salt water solution to flush intravenous ports) that expired on [DATE]; one 3 cc syringe with a needle attached that expired [DATE]; twelve angiocaths (a thin plastic tube inserted into a vein using a needle, allowing for the administration of fluids and medications), including three 22 gauge angiocaths that expired on [DATE], and one that expired on [DATE]; four 24 gauge angiocaths that expired on [DATE], and five 24 gauge angiocaths that expired [DATE]. In addition, there were two culture and sensitivity test kits that expired [DATE]; two blood drawing needles and three claves (rubber needled connectors) that expired [DATE]; one 15 ml bottle of hemocult developer that expired [DATE], and 32 hemocult test screening cards that expired [DATE].</p> <p>Interview with Licensed Practical Nurse 1 on [DATE], at 10:00 a.m. confirmed that the above listed gels and creams were in use with the seals broken; therefore, an open date and expiration date sticker should have been placed on them. Also, outdated medical equipment should be discarded and not in circulation.</p> <p>Observations in Highlands medication cart 1 on [DATE], at 9:43 a.m. revealed that there was one 30 gram container of 0.1 percent triamcinolone acetamide cream that was opened and not dated with the open date or expiration date.</p> <p>Interview with Licensed Practical Nurse 2 on [DATE], at 9:48 a.m. confirmed that the triamcinolone acetamide cream was in use with the seal broken and should have been marked with an opening date and expiration date, and it was not.</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 the Director of Nursing on [DATE], at 2:43 p.m. confirmed that expired equipment should not be in circulation, and that opened medications should be properly labeled as per facility policy.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy 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 - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that dietary staff wore appropriate hair coverings.</p> <p>Findings include:</p> <p>The facility's policy regarding personal hygiene, dated March 12, 2025, indicated that food is prepared, stored and distributed in a safe and sanitary manner preventing the spread of food borne illness.</p> <p>Observations in the 100-200 hall kitchenette during service for the lunch meal on June 2, 2025, at 11:48 a.m. revealed that Dietary Aide 3 was plating baked beans and hot dogs. Dietary Aide 3 had approximately three-inch tendrils of hair on each side of her head, and approximately two inches of loose hair on the nape of her neck that was not covered by her hairnet.</p> <p>Observations in the 100-200 hall kitchenette during service for the lunch meal on June 3, 2025, at 12:10 p.m. revealed that Dietary Aide 3 was plating hamburgers on a bun, and at the same time, she was standing over dishes of uncovered vanilla pudding. Dietary Aide 3 had approximately two inches of hair on each side of her head, and approximately two inches of loose hair on the nape of her neck that was not covered by her hairnet. Dietary Aide 4 was assisting the meal preparation by filling drinks and placing them on the trays. As she placed the drinks on the trays she passed over 13 dishes of uncovered pudding. Dietary Aide 4 had approximately three to four inches of hair on her bangs that was outside of her hairnet. Observations of Dietary Aide 5 revealed that she was assisting with plating hamburgers while standing over uncovered pudding dishes. Dietary Aide 5 had approximately two inches of hair on the nape of her neck that was not covered with a hairnet.</p> <p>Interview with the Dietary Manager on June 3, 2025, at 12:15 p.m. confirmed that Dietary Aides 3, 4, and 5 should have had their hair covered when plating and working around uncovered food in the 100-200 hall kitchenette.</p> <p>28 Pa. Code 211.6(f) Dietary Services.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies.</p> <p>Findings include:</p> <p>The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) survey ending July 11, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending June 5, 2025, identified repeated deficiencies related accuracy of assessments, care plan timing and revision, pharmacy services, and food safety.</p> <p>The facility's plan of correction for a deficiency regarding accuracy of assessments, cited during the survey ending July 11, 2024, revealed that accuracy of assessments would be monitored by QAPI. The results of the current survey, cited under F641, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding accuracy of assessments.</p> <p>The facility's plan of correction for a deficiency regarding care plan timing and revision, cited during the survey ending July 11, 2024, revealed that the care plan timing and revision would be monitored by QAPI. The results of the current survey, cited under F657, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding care plan timing and revision.</p> <p>The facility's plan of correction for a deficiency regarding pharmacy services, cited during the survey ending July 11, 2024, revealed that pharmacy services would be monitored by QAPI. The results of the current survey, cited under F755, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding pharmacy services.</p> <p>The facility's plan of correction for a deficiency regarding food safety, cited during the survey ending July 11, 2024, revealed that food safety would be monitored by QAPI. The results of the current survey, cited under F812, revealed that the QAPI committee was ineffective in maintaining compliance with food safety.</p> <p>Refer to F641, F657, F755, F812.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on a review of established infection control guidelines, facility policy, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for one of 33 residents reviewed (Resident 67).</p> <p>Findings include:</p> <p>Current CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply.</p> <p>The facility's policy regarding Enhanced Barrier Precautions (EBP), dated March 12, 2025, revealed that the required PPE during high contact resident activities included gloves and gown being donned (worn) with high-contact care activity (which includes wound care).</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 67, dated May 15, 2025, revealed that the resident was cognitively intact and had pressure ulcers. A physician's order for Resident 67, dated June 2, 2025, included an order for the resident to have Enhanced Barrier Precaution isolation.</p> <p>Observations of wound care for Resident 67 on June 4, 2025, at 11:15 a.m. revealed that there was no signage posted outside the resident's door to alert staff of the need for EBP. Licensed Practical Nurse 6 entered the room and completed wound care on Resident 67 without donning a gown per the EBP requirements.</p> <p>Interview with Registered Nurse Supervisor 7 on June 4, 2025, at 12:20 p.m. confirmed that Resident 67 should have had EBP signage at his door to alert staff of the necessary PPE when performing care on his pressure ulcer.</p> <p>Interview with the Assistant Director of Nursing on June 4, 2025, at 12:50 p.m. confirmed that Resident 67 should have had a sign outside his room indicating that he was on EBP and that Licensed Practical Nurse 6 should have worn a gown when performing wound care.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		