STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395577	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Washington Rehabilitation and Nursing Ctr	36 Old Hickory Ridge Rd Washington, PA 15301

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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43725 Based on clinical record review, staff interview, and observation, it was determined that the facility failed to provide an environment and care to promote dignity during medication administration for each resident's quality of life for five of nine residents observed (R226, R178, R119, R131, and R214). Findings include: Review of the facility policy Medication Administration/Disposition reviewed 2/28/24, indicated medications will be administered in a safe and timely manner. Facility staff involved in the administration of resident care will be knowledgeable of the policies and procedures regarding pharmacy services including medication administration. For residents not in their room or otherwise unavailable to receive medication on the pass, the Medication Administration Record (MAR) may be flagged. After completing the medication pass, the nurse will return to the missed Resident to administer the medication. Review of the facility policy Resident Rights reviewed 2/28/24, indicated employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of the facility and include a dignified existence. Review of the clinical record indicated Resident R226 was admitted to the facility on [DATE], with diagnoses that included dementia (gradual decline in memory, thinking, and social abilities severe enough to interfere with daily functioning), depression, and muscle weakness. Review of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 2/3/24, revealed the diagnoses remain current. Review of the physician orders revealed the following active medications to be administered at 9:00 a.m.: Atenolol (high blood pressure) 25 milligrams (mg) one time a day. Clonidine (high blood pressure) 0.1 mg one time a day. Donepezil (dementia)10 mg one time a day. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Memantine (dementia) 5 mg one time a day. Oxybutynin (bladder spasms/urgency)10 mg one time a day. Potassium Chloride (supplement) 10 milliequivalents (MEQ) one time a day. Wellbutrin (anti-depressant) 150 mg one time a day. Depakote sprinkles (mood conditions) 125 mg, two capsules two times a day. Hydrochlorothiazide (high blood pressure) 25 mg two times a day. During an observation on 4/9/24, at 8:30 a.m. Licensed Practical Nurse (LPN) Employee E1 was observed administering Resident R226's medications at a table in the middle of 1 [NAME] Nursing Unit with other residents seated at the table, at other tables nearby, and walking around the unit. Review of the clinical record indicated Resident R178 was admitted to the facility on [DATE], with diagnoses that included dementia, anxiety, and depression. Review of the physician orders revealed the following active medications to be administered at 9:00 a.m.: Aspirin 81 mg one time a day. Escitalopram (anti-depressant) 10 mg one time a day. During an observation on 4/9/24, at 8:37 a.m. LPN Employee E1 was observed administering Resident R178's medications at a table in the middle of 1 [NAME] Nursing Unit with other residents seated at the table, at other tables nearby, and walking around the unit. Review of the clinical record indicated Resident R119 was admitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania). Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of the physician orders revealed the following active medications to be administered at 9:00 a.m.: Lisinopril (high blood pressure) 40 mg one time a day. Meloxicam (treats pain and inflammation caused by arthritis) 15 mg one time a day. Sertraline (anti-depressant) 50mg one time a day. Sodium chloride (regulates amount of water in your body) 1 gram, two tablets one time a day. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Amantadine (treats stiffness, tremors, shaking, and uncontrolled movements) 100 mg two times a day. Metformin (diabetes) 500 mg two times a day; Psyllium (bulk-forming laxative) one packet two times a day; Valproic Acid (treats mood disorders) solution 10 milliliter (ml) two times a day. During an observation on 4/9/24, at 8:50 a.m. LPN Employee E1 was observed administering Resident R119's medications at a table in the middle of 1 [NAME] Nursing Unit with other residents seated at the table and at other tables in the area. Review of the clinical record indicated Resident R131 was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder, diabetes, and anxiety. Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of the physician orders revealed the following active medication orders to be administered at 9:00 a. m.: Carvedilol (treats high blood pressure and heart function problems) 12.5 mg two times a day. Eliquis (lowers risk of stroke and blood clots) 5 mg two times a day. Metformin 1000 mg two times a day. Amantadine (treats uncontrollable movements) 100 mg three time a day. Depakote sprinkles 125 mg three times a day. Gabapentin (treats nerve pain) 300 mg three times a day. Haloperidol (antipsychotic) 10 mg three times a day. Klonopin (treats anxiety) 1 mg three times a day. During an observation on 4/9/24, at 9:00 a.m. LPN Employee E1 was observed administering Resident R131's medications at a table in the middle of 1 [NAME] Nursing Unit with other residents seated at the table and at other tables in the area. Review of the clinical record indicated Resident R214 was admitted to the facility on [DATE], with diagnoses that included diabetes, chronic obstructive pulmonary disease (COPD - restricts airflow from the lungs), and chronic atrial fibrillation (irregular and very fast heart rhythm). Review of the MDS dated [DATE], revealed the diagnoses remain current. Review of the physician orders revealed the following active medication orders to be administered at 9:00 a. m.: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Calcium carbonate (supplement) 1250 mg one time a day. Fluoxetine (antidepressant) 40 mg one time a day. Lantus insulin (long-acting type of insulin that works slowly, over about 24 hours) inject 14 units one time a day. Sennosides (laxative) 8.6 mg one time a day. Eliquis 5 mg two times a day. Norco (narcotic pain medication) 5/325 mg two times a day. During an observation on 4/9/24, at 9:05 a.m. LPN Employee E1 was observed administering Resident R214's medications at a table in the middle of 1 [NAME] Nursing Unit with other residents seated at the table and at other tables in the area. She asked Resident R214 if he would like the insulin injected into his abdomen two separate times before Resident R214 responded I'd rather not while holding his shirt down at his waist. LPN Employee E1 then proceeded to administer the insulin in Resident R214's right upper arm. Residents R119, R131, and R214 were seated at a table together. Residents R226 and R178 were seated at separate tables with other residents. During an interview on 4/10/24, at 2:00 p.m. the Director of Nursing confirmed the to provide an environment and care to promote dignity for Resident R226, R178, R119, R131, and R214 during medication administration. 28. Pa Code: 201.29(i) Resident rights.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43725 Based on review of clinical records, facility policy, manufacture instruction, observation, and staff interview, it was determined that the facility failed to make certain the services provided or arranged by the facility meet professional standards of quality for one of five residents (Resident R214) Findings include: A review of the facility policy Facility Competence Program reviewed 2/28/24, indicated employees and contractors in all departments will participate in an ongoing program to assess and demonstrate knowledge, skills, and judgments required to perform job duties. A review of the manufacture instructions for the use of Lantus Kwik Pen (insulin injection pen) indicated Do not use a syringe to remove Lantus from the disposable prefilled pen. A review of the clinical record revealed that Resident R214 was admitted to the facility on [DATE], with diagnoses that included diabetes, depression, and muscle weakness. A review of a physician order dated 2/9/24, indicated to give Lantus Kwik Pen 14 units under the skin one time a day. A review of the comprehensive care plan initiated 2/19/24, indicated staff to administer insulin as ordered. During an observation of a medication administration on 4/9/24, at 9:05 a.m. Licensed Practical Nurse (LPN) Employee E1 was observed drawing insulin out of a Kwik Pen without using a Kwik Pen compatible needle for Resident R214. During an interview on 4/9/24, at 9:05 a.m. LPN Employee E1 stated that she often uses a syringe to remove insulin from the Kwik Pens to administer to the residents, stating she used this practice at other facilities that she worked at. During an interview on 4/12/24, at 8:57 a.m. Registered Nurse Employee E5 stated she sometimes uses a syringe to remove insulin from a Kwik Pen. During an interview on 4/12/24, at 10:45 a.m. the Director of Nursing confirmed the facility failed to make certain the services provided or arranged by the facility meet professional standards of quality for Resident R214. 28 Pa. Code 201.29(d) Resident rights. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43725 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels and failed to assess residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood glucose), for two of five residents reviewed (Residents R14, and R229). Findings include: The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it ' s untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. Review of the facility policy Hyperglycemia Management - Diabetes Management reviewed 4/18/23 and 2/28/24, indicated the facility will manage the resident's diabetes to prevent hyperglycemia based on physician orders and monitoring. The licensed nurse will obtain a blood glucose reading. The charge nurse/unit manager will contact the physician if the blood glucose is above 350, or the physician ordered parameters, or if signs and symptoms noted. A repeat blood glucose reading should be taken one hour after treatment has been given. Document the episode, assessment, and treatment in the nurses progress. Document medications and glucose levels in the electronic Medication Record (eMAR). Review of the facility policy Change of Condition reviewed 4/18/23 and 2/28/24, indicated the clinical nurse will recognize and appropriately intervene in the event of a change in resident condition. The facility will notify the resident, attending physician, and resident representative of changes in the resident's condition and/or status. Review of the clinical record indicated Resident R14 was readmitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and severe obesity. Review of Resident R14' s Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 3/18/24, indicated the diagnoses remain current. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician ' s order dated 1/27/24, indicated to inject Lispro (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) inject 22 units three times a day notify MD (medical doctor) of BS (blood sugar) less than 60 or greater than 450. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 3/7/24, at 9:19 a.m. CBG was noted to be 470. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of the care plan dated 6/23/21, indicated to administer diabetes medication as ordered. Monitor for side effects and effectiveness. Administer insulin as ordered. Monitor blood sugars as ordered. Monitor, document, and report signs/symptoms of hyperglycemia. Review of a clinical record indicated Resident R229 was readmitted to the facility on [DATE], with diagnoses that included diabetes, muscle weakness, and depression. Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of physician ' s orders dated 12/11/23, indicated insulin Aspart (a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) per sliding scale. For blood glucose greater than 400 give 36 units and notify MD. Review of Resident R14's eMAR revealed that the resident's CBG's were as follows: On 12/26/23, at 4:21 p.m. CBG was noted to be 474. On 1/4/24, at 4:46 p.m. CBG was noted to be 403. On 2/13/24, at 1:03 p.m. CBG was noted to be 401 On 2/23/24, at 12:42 p.m. CBG was noted to be 416. On 3/2/24, at 11:57 a.m. CBG was noted to be 435 On 3/3/24, at 12:21 p.m. CBG was noted to be 495. On 3/15/24, 8:54 p.m. CBG was noted to be 444. A review of Resident R229's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, failed to follow interventions of the care plan, blood sugar was not rechecked, and the physician was not notified of abnormal results. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident R229's care plan dated 5/31/23, indicated to administer insulin as ordered. Monitor blood sugars as ordered per sliding scale and notify MD of BS less than 60 or greater than 400. Monitor, document. report signs and symptoms of hyperglycemia. During an interview on 4/12/24, at 8:50 a.m. Licensed Practical Nurse (LPN) Employee E7 stated if the blood glucose was outside of the ordered parameters they would call the doctor, and document under progress notes During an interview on 4/12/24, at 8:53 a.m. LPN Employee E8 stated for blood sugars over 400 or over ordered parameters, they would call the doctor for orders, give ordered insulin, and document in the progress notes. During an interview on 4/12/24, at 8:55 a.m. Registered Nurse (RN) Employee E6 stated for blood glucose over the ordered parameters or over 400 without parameters they would call the doctor and document in the progress notes. During an interview on 4/12/24, at 8:59 a.m. RN Employee E5 stated for blood sugars over 450 they would give the ordered insulin, call the doctor, and recheck blood glucose in 10 minutes. They would document in the progress notes, the MAR, and under vitals for blood glucose. During an interview on 4/12/24, at 9:06 a.m. LPN Employee E9 stated for blood glucose over 450 she would call the doctor, give the ordered insulin, and document in the progress notes and vital signs for blood glucose. During an interview on 4/11/24, at 11:00 a.m. the Director of Nursing confirmed the facility failed to notify the doctor of a change in condition related to blood glucose, failed to follow the care plan interventions, and failed to recheck blood sugars for Residents R14, and R229. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49469

Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store medications and biologicals properly and securely in three of six medications carts (One [NAME] Front Hall, Three East Back Hall and Three South Front Hall).

Findings include:

Review of the facility policy Medication Storage-Med Cart last reviewed 2/28/24, indicated the nurse must secure the medication cart during the medication pass to prevent unauthorized entry. Medication carts must be securely locked at all times when out of the nurses's view. During medication pass, the Medication Administration Record (MAR) or Electronic Health Record (EHR) will be closed when not accessed by the nurse so that HIPPA information is not visible or accessible to unauthorized individuals.

Review of the facility policy Medication Storage last reviewed 2/28/24, indicated the medication supply is accessible only to nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received. The nursing staff shall be responsible for maintaining medication storage.

Review of the facility policy Medication Administration/Disposition reviewed 2/28/24, indicated during administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication.

During an observation on 4/9/24, at 8:30 a.m. One [NAME] Front Hall medication cart was observed unlocked, with the EHR visible on the laptop screen, and four medication cups with medication inside labeled with four resident room numbers.

During an interview on 4/9/24, at 8:50 a.m. Licensed Practical Nurse (LPN) Employee E1 stated the residents were not in their room when she went to give them their medications, and confirmed she left medications on top of the cart, and the cart left unattended and unlocked with resident medical information accessible to residents, visitors, and staff.

During an observation on 04/09/24, at 9:48 a.m. Three East Back Hall medication cart was left unattended and unlocked.

During an interview on 04/09/24, at 9:50 a.m. LPN Employee E4 confirmed the Three East Back Hall medication cart was left unattended and unlocked.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/9/24, at 10:06 a.m. it was revealed that the Three South Front Hall medication cart's top drawer contained unlabeled: 1. [NAME] hand cream. 2. Bath and body work hand sanitizer. 3. Carmex lip moisturizer. During an interview on 4/9/24, at 10:14 a.m. LPN Employee E3 stated those are mine and confirmed that the three south front hall medication cart contained improperly stored biologicals. During an observation on 4/12/24, at 8:55 a.m. Three East Front Hall medication cart was left unattended and unlocked in the hall outside of room [ROOM NUMBER] facing outwards making is accessible to residents, staff, and visitors. A nurse was observed in room [ROOM NUMBER] behind the privacy curtain with her back to the door. During an interview on 4/12/24, at 8:58 a.m. Registered Nurse (RN) Employee R6 confirmed she left the medication cart unattended and unlocked in the hall. 28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services. 28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services.