

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395582	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/19/2024
NAME OF PROVIDER OR SUPPLIER  Mountain City Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  403 Hazle Township Boulevard Hazleton, PA 18202	

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 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21738</p> <p>Based on review of clinical records and staff and resident interview, it was determined that the facility failed to incorporate preferred resident schedules into the residents' daily routine and to allow resident to make choices about aspects of their life that were important to them as evidenced by three of 35 sampled residents (Resident 19, 26 and 64).</p> <p>Findings include:</p> <p>Review of Resident 19's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses of hemiplegia (paralysis of one side of the body) unspecified side and chronic obstructive pulmonary disease ([COPD]a respiratory disease characterized by persistent respiratory symptoms like progressive breathlessness and cough).</p> <p>An annual Minimum Data Set ([MDS] - a federally mandated assessment of a resident's abilities and care needs) dated August 20, 2023, at 12:03 PM revealed that it was somewhat important to the resident to go outside to get fresh air when the weather is good.</p> <p>Review of Resident 19's current care plan with a revision date of February 29, 2024, indicated that the resident participates actively in room activities of choice and will occasionally accept escort to group activities with a goal of participating actively with daily activities of choice. Planned interventions are for activity staff to provide a monthly calendar of events and invite and escort the resident to groups of his choice.</p> <p>A quarterly MDS assessment dated [DATE], revealed that the resident was moderately cognitively impaired with a BIMS score of 8 severe (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information) and was dependent on staff for substantial/maximal assistance for all activities of daily living (ADL) and transfers.</p> <p>During an interview with Resident 19 on April 16, 2024, at 9:56 AM the resident was observed in his room, lying in his bed. The resident stated that he enjoys going to church but would really love to be able to go outside and get some fresh air.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Employee 1, Certified Nurse Aide (CNA), on April 18, 2024, at 11:10 AM revealed that the residents, including Resident 19, often complain of not being able to go outside, saying that they were not prisoners and should be able to go outside for fresh air. Employee 1 stated that the activities department staff is responsible for bringing the residents outside and she does not ever see this happen. She states that the only residents that go outside consistently are the residents who smoke.</p> <p>During an interview with Employee 3, Director of Life Enrichment Services (DLES) on April 18, 2024, at 2:45 PM revealed that the residents do go outside for fresh air breaks. Employee 3 stated there is no established list or scheduled times, for residents wishing to go outside for fresh air breaks. Employee 3 stated that outdoor activities will be scheduled, weather permitting, but for residents not attending a scheduled activity outside, there was no established schedule for activities staff to assist those residents outside for fresh air breaks.</p> <p>Review of Resident 26's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses of COPD and major depressive disorder ([MDD] a mental health disorder having episodes of psychological depression [sadness]).</p> <p>Review of document titled Resident Centered Care/All About Me Information Form - V2.0 dated February 11, 2024, at 12:01 PM indicated that the resident preferred showering in the AM hours independently with supervision.</p> <p>A quarterly MDS for Resident 26, dated February 14, 2024, revealed that the resident had moderate cognitive impairment, with a BIMS score of 12. The resident showered independently with supervision.</p> <p>During an interview conducted with Resident 26 on April 16, 2024, at 9:26 AM the resident stated that when she showers, she likes to also wash her hair but because she is a smoker she is not allowed to go outside with wet hair and staff are unable to accommodate her by allowing her to take a shower after her smoke break. Therefore, she skips washing her hair when she showers to be able to go outside for a smoke break.</p> <p>During an interview on April 16, 2024, at 11:02 AM with the Nursing Home Administrator (NHA) revealed that scheduled smoking times are at 8:30 AM, 11:00 AM, 2:00 PM, 4:30 PM and 8:00 PM. The NHA stated that all residents are supervised in the shower, therefore, Resident 26 would not be able to shower without staff present.</p> <p>Review of Resident 26's Kardex tasks dated April 17, 2024, indicated that the resident was scheduled for a shower every Wednesday and Saturday during 3:00 PM to 11:00 PM shift.</p> <p>Review of Resident 64's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses of depressive (sadness) episodes and reduced mobility.</p> <p>An admission MDS for Resident 64, dated March 22, 2024, revealed that the resident was cognitively intact with a BIMS of 14 and that it was very important for her to do her favorite activities.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 64's current care plan dated March 29, 2024, indicated the resident would engage in her own independent activities such as television and word puzzles with a goal that the residents activity wishes will be honored through the next review with planned interventions to provide the resident with a monthly calendar of activities and invite and escort to the activities of choice and encourage social activities.</p> <p>Interview with Resident 64 on April 16, 2024, at 10:01 AM revealed that the resident stated that she is a smoker and is upset that some of the activity times are scheduled at the same time as her smoking breaks. She states that the 2:00 PM activities are usually the ones that are the best that she would like to attend but also does want to be able to go out and smoke in the mid afternoon as well. She states that she has mentioned this conflict several times to staff and their response to her was that she would have to split the time to be able to attend both the activity and the smoking break. She stated that you cannot go to a BINGO game halfway through the game.</p> <p>Interview with the NHA and Director of Nursing (DON) on April 19, 2024, at 1:45 PM, confirmed that the facility failed to reasonably accommodate preferred resident schedules into the residents' daily routines and allow residents to make choices about aspects of their life that were important to them.</p> <p>28 Pa. Code 201.29 (a) Resident rights</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 41581</b></p> <p>Based on observations and staff interview, it was determined that the facility failed to maintain a clean and orderly environment on four of five resident units (Nursing Unit 2, 3, 4, 5 in the blue and white buildings)</p> <p>Findings include:</p> <p>Observations on April 16, 2024, at approximately 11:15 AM of the Unit 4 second floor of the blue building revealed the following:</p> <p>The closet door handles were broken off and the door was unable to open or close properly with several items on the floor inside the closet of resident room [ROOM NUMBER]. There were two large bags observed on the floor that contained several personal items that included food. The bathroom had a strong urine smell. In the hallway exiting this room there was a strong odor of feces.</p> <p>A ceiling block was missing directly above an occupied resident bed in resident room [ROOM NUMBER]. There was an unattended wheeled cart, a toolbox, tools and the ceiling block with dirt and debris covering the floor in this room</p> <p>room [ROOM NUMBER] was noted to have two large boxes were on the floor in Resident room [ROOM NUMBER], along with several positional wedge cushions stacked on top. A broda reclining wheelchair was observed with several items piled up on the seat of the chair. Two bedside tables in the room observed to dirty with sticky substances and debris adhering to the surface. A urinal half filled with a yellow urine like substance was observed on the floor.</p> <p>room [ROOM NUMBER] was noted to have two meal trays with food from breakfast was observed on the dresser in Resident room [ROOM NUMBER], and an offensive foul odor was detected in the room.</p> <p>Observations on April 16, 2024, at approximately 11:45 AM of the Unit 5 third floor of the blue building revealed the following:</p> <p>The heating unit vent was detached from the base in resident room [ROOM NUMBER]. The over-the-bed table tray veneer coating was chipped and cracked along the edges and a 8-inch by 2-inch portion of veneer was torn away on the top of the tray. The privacy curtain was stained with multiple brown stains.</p> <p>In resident room [ROOM NUMBER], heating unit vent was detached from the base. The night light cover was loose and coming off the wall. There are multiple gouges in the wall outside the bathroom door. There are approximately 70 staples in the wall next to the window.</p> <p>In resident room [ROOM NUMBER] the middle drawer of the nightstand would not close. The privacy curtains were stained with brown and white substances.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on April 17, 2024, at approximately 10:50 AM of the Unit 3 first floor of the blue building revealed the following:</p> <p>Dried brown streaks were observed on the wall next to the bed room sink in resident room [ROOM NUMBER]. Dirt and debris was observed on the bathroom floor in this same room; brown spots were on the walls in the bathroom and there was a strong urine smell in the bathroom.</p> <p>Observation in resident room [ROOM NUMBER] revealed a tube feeding pole and pump coated with a large amount of thick dried tube feeding formula on the base of the pole, dried tube feeding formula dripped down the pole and onto the feeding pump.</p> <p>The bathroom tiles in the bathroom of resident room [ROOM NUMBER] were stained with brown spots. On top of the back of the toilet, there was two graduated cylinders and one urinal that contained a yellow urine like substance in the bottom of the containers. The bathroom had a strong smell of urine.</p> <p>A tied up dirty garbage bag was on the floor in resident room [ROOM NUMBER]. Food debris was observed on the floor. Sticky drip spots were observed on the wall next to the bathroom door and sink. [NAME] spots were observed on the tile in the bathroom. A graduated cylinder was on top of the toilet with a yellow urine like substance in the bottom of cylinder. The bathroom had a strong urine smell. The wall molding was missing on the wall next the closet.</p> <p>In resident room [ROOM NUMBER], a brown substance was observed around the bottom of the toilet. Two urinals with a yellow urine like liquid substance in the bottom of them were on the back of the toilet. A strong urine smell was detected in the bathroom. Large gouges were observed on the wall, behind the residents' beds.</p> <p>Observations in resident room [ROOM NUMBER] revealed that the closet door handles were broken off and brown spots were observed on the closet doors.</p> <p>Observations on April 17, 2024, at approximately 10:51 AM of the Unit 4 second floor of the blue building revealed the following:</p> <p>Observations in resident room [ROOM NUMBER] revealed a large brown stain on the ceiling block and stains that appeared as substance was dripping down the wall, starting from the ceiling block, extending downwards, in the bathroom.</p> <p>Observation on April 18, 2024, at 11:30 AM of Unit 2 second floor of the white building revealed that the phone in Resident room [ROOM NUMBER]-W was visibly soiled and sticky.</p> <p>There was a build-up of dirt on the metal base of the over-the-bed table located at 215-W.</p> <p>The fabric of a chair located in room [ROOM NUMBER]-D was soiled.</p> <p>Interview with the Director of Nursing on April 19, 2024, at approximately 1:45 PM confirmed the facility is to be maintained daily to provide a clean and sanitary environment for the residents.</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>48277</p> <p>Based on observations, review of select facility policy and staff interviews, it was determined that the facility failed to make information and forms accessible regarding the facility's grievance/complaint process and the residents' rights to file a grievance anonymously in prominent locations on four of seven floors in the facility (blue and white buildings).</p> <p>Findings include:</p> <p>Review of the facility's policy titled Concern Resolution and Grievance Procedure last reviewed by the facility on January 16, 2024, indicated that each resident has the right to file grievances orally (spoken) or in writing, and the right to file grievances anonymously. If choosing to report anonymously, residents can fill out a Concern/Grievance Form located on each floor in each lobby. Once the form is completed, residents can place it in the black boxes located on each floor on each lobby.</p> <p>Observation of the Blue building first-floor nursing unit on April 19, 2024, at 10:10 AM revealed there were no postings to indicate the location of grievance forms, the process of filing a grievance, the expectation of how long it would take the facility to resolve a grievance, identification of the facility's grievance official, and how to contact the grievance official. There was no posting to indicate how to file a grievance anonymously. In addition, there were no concern/grievance forms available for residents and no black box available to file a grievance anonymously in the lobby of the first-floor nursing unit.</p> <p>Observation of the Blue Building second-floor nursing unit on April 19, 2024, at 10:15 AM, revealed there were no postings to indicate how to file a grievance form, the process of filing a grievance, the expectation of how long it would take the facility to resolve a grievance, identification of the facility's grievance official, and how to contact the grievance official. There was no posting to indicate how to file a grievance anonymously.</p> <p>Observation of the Blue Building third-floor nursing unit on April 19, 2024, at 10:20 AM revealed there were no postings to indicate the location of grievance forms, the process of filing a grievance, the expectation of how long it would take the facility to resolve a grievance, identification of the facility's grievance official, and how to contact the grievance official. There was no posting to indicate how to file a grievance anonymously. In addition, there were no concern/grievance forms available for residents and no black box available to file a grievance anonymously in the lobby of the third-floor nursing unit.</p> <p>Observation of the [NAME] Building Lobby on April 19, 2024, at 10:40 AM revealed there were no postings to indicate how to file a grievance form, the process of filing a grievance, the expectation of how long it would take the facility to resolve a grievance, identification of the facility's grievance official, and how to contact the grievance official. There was no posting to indicate how to file a grievance anonymously.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Nursing Home Administrator on April 19, 2024 at approximately 11:00 AM acknowledged that the facility failed to post the grievance process procedural information, to include how to file a grievance anonymously and that no grievance forms/boxes were present on the first and third floor nursing units.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29 (a)(c) Resident rights</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21738</p> <p>Based on review of clinical records, the facility's abuse prohibition policy, and select investigative reports, and staff interviews, it was determined that the facility failed to ensure that six residents (Residents 212, 93, 203, 178, 487, and 152) were free from physical abuse perpetrated by other residents (Residents 3, 188, 225, 212, 221, 213, and 56) out of 41 residents sampled for abuse prevention, which resulted in serious harm and injury to one resident, a fractured leg and hip (Resident 203).</p> <p>Findings include:</p> <p>A review of a facility policy entitled Pennsylvania Resident Abuse: Abuse, Neglect, and Exploitation, dated August 30, 2023, revealed that it is the policy of the facility to not tolerate abuse, neglect, mistreatment, exploitation of residents, or misappropriation of resident property by anyone. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>A review of Resident 212's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included dementia with behavioral disturbances (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning).</p> <p>A review of the resident's Quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated December 18, 2023, revealed that the resident was severely cognitively impaired.</p> <p>A review of Resident 3's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included dementia and unspecified psychosis.</p> <p>The resident's Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was severely cognitively impaired.</p> <p>A facility investigation report dated January 3, 2024, revealed that at 8:40 PM Resident 212 was outside Resident 3's room. The residents appeared to be arguing. At that time Resident 3 hit Resident 212 in the left side of her face.</p> <p>A review of a witness statement from Employee 6, NA (nurse aide), dated January 3, 2024, revealed that the employee was walking through the hallway when she heard Resident 212 and Resident 3 arguing. Employee 6 indicated she walked over to see what was going on and saw Resident 3 hit Resident 212 on the cheek.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a witness statement from Employee 7, NA, dated January 3, 2024, indicated that she was in front of Resident 3's room and heard the residents arguing. The employee indicated that she and Employee 6 were telling the residents to calm down and Resident 3 hit Resident 212.</p> <p>Applying the reasonable person concept, in the case of Resident 212, who is unable to speak for herself, and the assessment of how most people would react to the situation of being physically abused by Resident 3, Resident 212 would have suffered psychosocial harm and humiliation.</p> <p>An interview with the Nursing Home Administrator and Director of Nursing on April 19, 2024, at approximately 1:45 PM confirmed the facility failed to ensure that Resident 212 was free from physical abuse perpetrated by Resident 3.</p> <p>A review of Resident 212's clinical record revealed admission to the facility on [DATE], with diagnoses to include dementia with other behavioral disturbances (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change), anxiety, and major depressive disorder (persistent depressed mood or loss of interest in activities).</p> <p>A quarterly Minimum Data Set assessment dated [DATE], indicated that the resident was severely cognitively impaired with a BIMS (Brief Interview for Mental Status - a tool to assess cognition) score of 3 (0-7 represents severe cognitive impairment).</p> <p>The resident's initial care plan dated June 19, 2023, indicated that Resident 212 exhibited the following behaviors due to anxiety and depression: verbal aggression directed at others, non-nonsensical and rambled speech, exit-seeking, verbal outbursts, talking to self, removes clothes, wanders, yells at peers, propels self into other resident's rooms under stop sign, and holds/pushes other residents wheelchairs. The planned interventions were to administer medications as ordered, provide opportunity for positive interaction, encourage activity distraction, and reorient as needed.</p> <p>A review of Resident 178's clinical record revealed admission to the facility on [DATE], with diagnoses to include vascular dementia with behavioral disturbances, anxiety, and major depressive disorder with severe psychotic symptoms.</p> <p>A quarterly Minimum Data Set assessment dated [DATE], indicated that the resident was severely cognitively impaired with a BIMS score of 3.</p> <p>A nursing note dated February 9, 2024, at 9:45 PM indicated Resident 212 had increased confusion and behaviors, and was wandering into other residents' rooms. Nursing noted on February 12, 2024, at 1:00 AM indicated that Resident 212 exhibited increased agitation and restlessness and was wandering into residents' rooms looking for her purse and cigarettes. On February 12, 2024, at 10:28 AM nursing indicated that resident displayed agitation, increased anxiety and verbal outbursts. A nursing note dated February 12, 2024, at 12:55 PM indicated that Resident 212 had increased behaviors of yelling outbursts and cursing at staff. Nursing documentation dated February 14, 2024, at 7:34 PM indicated that Resident 212 had increased behaviors, yelling at staff and peers, wandering, and refusing assistance.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>A nursing note dated February 16, 2024, at 10:58 AM revealed Resident 212 was an aggressor of physical aggression with a peer. The note indicated that Resident 212 was observed wheeling herself into the dining room for activities. The Activities Assistant observed Resident 212 speaking loudly with a peer. The activities aide came and tried to separate the residents but was unable to do so prior to the physical incident occurring.</p> <p>Review of the facility investigation report dated February 16, 2024, at 10:20 AM, revealed that Resident 212 stood up from her wheelchair and punched another resident (Resident 178) on the left side of her face after a verbal aggression, causing Resident 178 to sustain a small abrasion.</p> <p>Review of the ACT-13 Mandatory Abuse Report dated February 16, 2024, at 12:15 PM, revealed the facility identified Resident 178 as the victim and Resident 212 as the perpetrator. The facility reported that Resident 178 was seated in the dining room participating in activities at 10:20 AM. At that time, Resident 212 was observed rolling in her wheelchair into the room, where the activities program was occurring. The activities aide could see Resident 212 and Resident 178 talking to one another and, as she walked over, Resident 212 stood up from her wheelchair and struck the left side of Resident 178's face. The actions taken by facility included immediately separating the resident and placing both on increased supervision. New orders for lab work obtained for Resident 212.</p> <p>A review of Employee 5 (Activities Assistant) witness statement dated February 16, 2024, (no time indicated) revealed that she was getting the morning snack ready for the residents around 10:15-10:20 AM when she heard Resident 212 arguing with Resident 178. She walked over to separate the residents but Resident 212 stood up from her wheelchair and punched Resident 178 in the left cheek. Resident 212 was removed from the dining room and two nurses' aides came in to assist. Afterwards, Resident 178 told Employee 5 that she called Resident 212 a whore in response to her repeatedly accusing Resident 178 of stealing her purse, clothes, etc.</p> <p>Applying the reasonable person concept, in the case of Resident 178, who is unable to speak for herself, and the assessment of how most people would react to the situation of being physically abused by Resident 212, Resident 178 would have suffered psychosocial harm and humiliation.</p> <p>The facility was aware of the physically aggressive behavior of Resident 212 but failed to demonstrate sufficient supervisory measures of this resident to monitor her whereabouts to prevent the physical abuse of another resident.</p> <p>During an interview with the Nursing Home Administrator on April 19, 2024, at approximately 9:45 AM, it was confirmed that the facility failed to protect Resident 178 from physical abuse and failed to effectively monitor and supervise a resident with known episodes of aggressive behaviors to prevent resident-to-resident altercations.</p> <p>Clinical record review revealed that Resident 93 had diagnoses, which included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning).</p> <p>Resident 93's quarterly Minimum Data Set assessment dated [DATE], indicated that the resident had severe cognitive impairment, had no behaviors, and required staff assistance for eating.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review revealed that Resident 188 was admitted to the facility on [DATE], and had diagnoses which included bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) and Lewy body dementia (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function).</p> <p>Resident 188's admission MDS assessment dated [DATE], indicated that the resident had severe cognitive impairment, inattention, disorganized thinking, verbal and physical behaviors, puts others at significant risk of physical injury, intrudes on the privacy or activity of others, and wandering behavior.</p> <p>A review of Resident 188's care plan, dated March 11, 2024, revealed that the resident was identified to exhibit behaviors due to cognitive status which include agitation, verbal outbursts, physical aggression, combativeness, stands unassisted, attempts to transfer, and attempting to hit, choke, and punch staff. Interventions planned were to allow resident to vent thoughts and feelings, always approach in a calm, relaxed manner, encourage to express feelings, listen with empathy and non-judgmental acceptance, compassion, and ensure residents feels safe in environment.</p> <p>A nurses note dated March 15, 2024 at 6:58 PM indicated that Resident 188 was observed hitting Resident 93 on top of the head while staff were feeding Resident 93. Employee 1, a nurse aide, witnessed the abuse, and attempted to redirect Resident 188, the aggressor. Resident 188 then struck Employee 1 (nurse aide) in the stomach and arms. Resident 188 was immediately redirected out of the area and brought to the resident's room. Physician and resident representative notified. Increased supervision per protocol. Plan to Redirect Resident 188 to high visibility areas to maintain watchful eye.</p> <p>Review of the facility investigation dated March 15, 2024, at 5:30 PM indicated that no injuries were observed to Resident 93 at the time of the incident.</p> <p>Review of Employee 1 (nurse aide)'s witness statement revealed that after Resident 188 hit Resident 93, Employee 1 made sure Resident 93 had no red marks on top of her head and Resident 93 seemed fine. Employee 1 was standing behind Resident 188's chair trying to redirect him to sit back down in his chair. As Employee 1 tried to redirect Resident 188, Resident 188 hit Employee 1 in the stomach and arm. Resident 188 became agitated while Employee 1 was assisting him back into his chair.</p> <p>Interview with employee 1 (nurse aide) on April 18, 2024, at 1:05 PM revealed that on the date of the incident she was feeding Resident 93 in the unit 5 (blue building third floor) dining room. At the same time, Resident 188 was also in the dining room at a table with other residents. Resident 188 was repeatedly attempting to stand from his wheelchair. Employee 1 stated that she was the only employee in the dining room at this time as other staff were passing meal trays in the hall for residents who eat in their rooms. Employee 1 stated that Resident 188 started hanging on the table with his hands while attempting to stand and seemed to be getting aggressive. Employee 1 brought Resident 188 closer to where she was feeding Resident 93 so she could supervise Resident 188. Resident 188 stood up again and when she asked him to sit down he grabbed the back of Resident 93's wheelchair and hit her on the top of the head. Employee 1 stated that Resident 93 did not seem to realize she was hit on the head. Employee 1 stated that Resident 188 then punched her twice. Employee 1 stated that after the incident she was able to get to the nurses station for assistance.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>The facility failed to protect Resident 93 from physical abuse and failed to effectively monitor and supervise a resident with known episodes of aggressive behaviors to prevent a physical abuse of another resident.</p> <p>Applying the reasonable person concept, in the case of Resident 93, who is unable to speak for herself, and the assessment of how most people would react to the situation of being physically abused by Resident 188, Resident 93 would have suffered psychosocial harm and potential injury.</p> <p>During an interview with the administrator on April 18, 2024, at 2:00 PM, it was confirmed that the facility failed to protect Resident 93 from physical abuse and failed to effectively monitor and supervise a resident with known episodes of aggressive behaviors to prevent a resident-to-resident altercation.</p> <p>A review of Resident 225's clinical record revealed admission to the facility on [DATE], with diagnoses to include dementia with other behavioral disturbances (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change), and paranoid schizophrenia (a severe mental health disorder in which a person interprets reality abnormally, experiencing hallucinations, delusions, and extremely disordered thinking and behaviors).</p> <p>An admission Minimum Data Set assessment dated [DATE], indicated that the resident was severely cognitively impaired with a BIMS score of 0.</p> <p>The resident's initial care plan dated February 5, 2024, and revised March 25, 2024, indicated that she was an independent ambulator on the unit and was impaired in her ability to make herself understood and to understand others related to Spanish-speaking only. According to the resident's care plan, she exhibited behaviors of repetitiveness, anxiousness, looking for her checks, refused activity programs and showers, and accusatory regarding her clothing. The planned interventions were to approach the resident in a calm manner, be reassuring, allow resident to vent thoughts and feelings, and ensure resident feels safe in environment.</p> <p>A review of Resident 203's clinical record revealed admission to the facility on [DATE], with diagnoses to include dementia, anxiety, and hypertension (a condition in which the force of the blood against the artery walls is too high)</p> <p>A quarterly Minimum Data Set assessment dated [DATE], indicated that the resident was severely cognitively impaired with a BIMS score of 0.</p> <p>A review of the resident's care plan, initially dated June 20, 2023, indicated that Resident 203 was bilingual, communicating in Hindi and English.</p> <p>A review of a nursing note dated March 22, 2024, at 7:35 PM revealed that Resident 203 was observed in the doorway of the lounge on the east wing of Blue 3. She was speaking in loud voice to Resident 225. According to the witness, the aggressor, Resident 225, pushed Resident 203 causing her to fall on the floor. The nurse, who witnessed the event, separated them immediately. Resident 203 was assessed for injuries and noted the resident with left leg in abduction. The resident was tearful and guarding her leg with her hands.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>A review of ACT-13 Mandatory Abuse Report dated March 22, 2024, at 7:15 PM identified Resident 203 as the victim and Resident 225 as the perpetrator. The report indicated that Resident 225 was observed to push Resident 203. Actions taken by the facility included immediate separation, increased supervision for the perpetrator and to send the victim to the ER to be evaluated for left hip abduction and pain. The report also indicated that both residents have a diagnosis of dementia.</p> <p>A review of an Employee 4's (licensed practical nurse) witness statement dated March 22, 2024, (no time indicated) revealed the date of the incident was March 22, 2024. According to the employee's witness statement she reported that Resident 203 was standing in the doorway of the South dining room. Resident 225 was standing in front of her, and they were speaking loudly to each other in their native languages. Resident 225 pushed Resident 203, and Resident 203, fell backwards. Resident 203's left leg was rotated out and she had pain with movement. The supervisor came to the floor to assess the resident.</p> <p>A nursing note on March 22, 2024, at 8:15 PM, revealed Resident 203 was sent to the hospital, where she was diagnosed with a left leg and hip fracture. Review of the x-ray report dated March 22, 2024, at 10:33 PM revealed that Resident 203 sustained an acute fracture of the left proximal femur (upper leg) and an acute nondisplaced fracture of the left hip as a result of the fall.</p> <p>A nursing note dated April 1, 2024, at 5:14 PM revealed Resident 203 was readmitted to the facility from the hospital on April 2, 2024, at 5:00 PM status post a left hip fracture.</p> <p>A review of Resident 203's Physical Therapy Evaluation upon return to the facility from the hospital dated April 2, 2024, revealed that the resident sustained a left hip fracture as a result of being pushed by another resident. The resident underwent a left hip ORIF (open reduction internal fixation- surgical procedure to stabilize and heal a broken bone using hardware to hold the bone together). Prior to the incident and fall, the resident was independent to transfer and ambulate on the unit. Since suffering the fall, fracture, and surgery, the resident was totally dependent on staff to stand and perform transfers. The resident was no longer able to ambulate.</p> <p>The facility failed to prevent the physical abuse of Resident 203 perpetrated by Resident 225, which resulted in Resident 203 being pushed to the ground, sustaining a left hip fracture which required surgical repair. As a result of the fall, Resident 203 experienced a significant decline in her functional abilities, transfers and ambulation and was now dependent on staff for her mobility needs.</p> <p>During an interview with the Nursing Home Administrator on April 19, 2024, at approximately 9:30 AM, it was confirmed that the facility failed to ensure that Resident 203 was free from physical abuse perpetrated by Resident 225.</p> <p>A review of Resident 221's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to have dementia with other behavioral disturbance.</p> <p>A quarterly MDS assessment dated [DATE], revealed that the resident was severely cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 487's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included mild neurocognitive disorder due to known physiological condition without behavioral disturbances and reduced mobility. An admission MDS dated [DATE], indicated the resident was cognitively intact.</p> <p>A progress note dated April 11, 2024, at 10:11 AM revealed that Resident 221 was noted to have verbal behaviors including yelling/screaming and verbal aggression towards staff and her roommate, Resident 487. She was encouraged to be respectful to roommate, no mood concerns at present time and staff will continue to monitor.</p> <p>A facility investigation dated April 12, 2024, at 1:24 AM revealed that staff heard yelling from Resident 221's and Resident 487's room. Upon entering the room staff observed Resident 221 attempting to remove a shirt from Resident 487, who was sitting on her bed. Resident 221 was stating that it was her shirt. While Resident 221 was attempting to remove the shirt from Resident 487, Resident 221 pulled Resident 487's hair. No injuries were noted. Staff separated the residents. Resident 221 stated she is going through my stuff; she is going to end up eating everything. Resident 221 was assessed to have a superficial scratch on her chest measuring approximately 4.5 centimeters (cm) long. Resident 221 was placed on increased supervision. The local police department and Area on Aging Agency (AAA) was notified of the altercation between the residents involved. Resident 487 had a room change to a different unit in the building.</p> <p>A review of a witness statement from Employee 4, Licensed Practical Nurse (LPN), dated April 12, 2024, revealed that the employee was working at the desk and heard yelling coming from the East wing, went down the hall and found Resident 221 trying to take a shirt off Resident 487's body and immediately separated the residents. Resident 487 was sitting on Resident 221's bed and holding Resident 221's necklace.</p> <p>A review of a witness statement from Resident 487 on April 12, 2024, revealed that I put the blue shirt on because it was cold and then {Resident 221} came in and thought I was stealing it, she tried pulling it off me until she took it off completely. I did not get hurt; I would have offered her money for it.</p> <p>Further review of progress notes dated April 12, 2024, at 1:36 AM revealed that during the altercation when Resident 221 forcefully attempted to remove a shirt from Resident 487. Resident 487 stated that she got me real good with those knuckle punches and pointed to her head.</p> <p>An interview with the NHA and DON on April 19, 2024, at approximately 1:45 PM confirmed the facility failed to ensure that Resident 487 was free from physical abuse perpetrated by Resident 221.</p> <p>Review of clinical record of Resident 213 revealed that the resident was admitted to the facility on [DATE], with diagnoses including dementia. A 5-Day/Admission Minimum Data Set assessment dated [DATE], indicated that Resident 213 was severely cognitively impaired with a BIMS score of 1.</p> <p>A review of Resident 152's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included schizoaffective disorder. A review of the resident's Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was moderately impaired with a BIMS score of 12.</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Some	<p>A review of Resident 213's clinical record revealed the resident had been intrusively wandering into other resident rooms since his admission on February 8, 2024, which occurred almost daily while in the facility.</p> <p>A review of a facility investigation dated February 21, 2024, revealed Resident 213 wandered into Resident 152's room and would not leave. Resident 152 punched Resident 213 in the face. Resident 152 went to the nurses' station and informed Employee 8 LPN that he had punched Resident 213 in the face.</p> <p>A review of a witness statement from Employee 8 LPN (Licensed Practical Nurse) dated February 21, 2024, revealed the employee was at the nurses' station when Resident 152 walked up to the desk and told her that Resident 213 came in his room and would not leave so he punched him in his face. Employee 8 noted that Resident 152 had blood on his hand. Employee 8 went to Resident 152's room and saw Resident 213 was still in Resident 152's room and he was on the floor and bleeding. Resident 213 was assisted back to his room and an ice pack was applied.</p> <p>Resident 213's clinical record revealed that the resident had a 3 cm by 3 cm laceration on his forehead. An x-ray was completed and there was no fracture to his nose noted.</p> <p>The facility failed to protect Resident 152 from physical abuse and failed to effectively monitor and supervise this resident with known episodes of intrusive wandering behaviors to prevent physical abuse.</p> <p>An interview with the NHA and DON on April 19, 2024, at approximately 1:45 PM confirmed the facility failed to ensure that Resident 152 was free from physical abuse perpetrated by Resident 213.</p> <p>A review of Resident 203's clinical record revealed admission to the facility on [DATE], with diagnoses to include dementia, anxiety, and hypertension (high blood pressure). A quarterly Minimum Data Set assessment dated [DATE], indicated that the resident was severely cognitively impaired with a BIMS score of 0.</p> <p>A review of Resident 56's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included schizophrenia. A review of the resident's Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was severely cognitively impaired.</p> <p>A review of a facility investigation dated January 29, 2024, revealed Resident 203 was outside Resident 56's room. Employee 10, NA (Nurse Aide), was taking Resident 56 out of her room and Resident 56 punched Resident 203 in the chest.</p> <p>A review of a witness statement from Employee 10 NA (nurse aide) dated January 29, 2024, revealed the Resident 56 was leaving her room and saw Resident 203 and started calling her derogatory names and then struck out and punched Resident 203 before Employee 10 could stop her.</p> <p>Applying the reasonable person concept, in the case of Resident 203, who is unable to speak for herself, and the assessment of how most people would react to the situation of being physically abused by Resident 56, Resident 203 would have suffered psychosocial harm and humiliation.</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Some	An interview with the Nursing Home Administrator and Director of Nursing on April 19, 2024, at approximately 1:45 PM confirmed that the facility failed to ensure that Resident 203 was free from physical abuse perpetrated by Resident 56.  28 Pa. Code 201.14 (a) Responsibility of licensee  28 Pa. Code 201.18 (e)(1) Management  28 Pa. Code 201.29 (a)(c) Resident Rights  28 Pa. Code 211.12(c)(d)(5) Nursing Services		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</b></p> <p>Based on select facility policy and clinical records, observations, and staff interview it was determined that the facility failed to consistently administer oxygen as ordered and maintain sanitary oxygen delivery systems for six out of 35 sampled residents (Resident 8, 26, 48, 59, 64 and 124).</p> <p>Findings included:</p> <p>According to the American Thoracic Society, O2 is a medication that requires a prescription from a healthcare provider. The provider will prescribe your O2 at a specific flow rate and a specific number of hours per day. It is very important that O2 is used as prescribed. Using too little O2 may put a strain on the heart and brain, causing heart failure, fatigue, or memory loss. Using too much O2 can also be a problem. For some patients, using too much O2 can cause them to slow their breathing to dangerously low levels. It is important to wear O2 as your provider ordered it. If the patient starts to experience headaches, confusion, or increased sleepiness after using supplemental O2, the patient may be getting too much.</p> <p>Review of a facility policy entitled Oxygen Administration last reviewed on January 16, 2024, indicated that licensed clinicians with demonstrated competence will administer O2 via the specified route as order by a provider. For O2 cylinder, verify tank is clearly labeled indicating O2 is the gas within the tank, check the cylinder gauge to assess adequacy of O2 supply. For O2 concentrator (bedside machine that concentrates ambient air to supply an oxygen-rich gas stream), plug in power cord, turn on and set flow meter to correct flow rate. When O2 not in use, store O2 tubing and nasal cannula or mask in separate, labeled plastic bag. Label bottles with the date and initials upon opening. Clean the concentrator and change tubing, mask, and cannula weekly and document according to facility policy.</p> <p>A review of clinical record revealed Resident 59 was admitted to the facility on [DATE], with diagnoses to include chronic respiratory failure (lung condition where organs have inadequate O2 supply due to fluid buildup in the lungs) with hypercapnia (presence of higher-than-normal level of carbon dioxide in the blood), chronic obstructive pulmonary disease ([COPD]a respiratory disease characterized by persistent respiratory symptoms like progressive breathlessness and cough). and morbid (severe) obesity with alveolar (relating to the alveolus of alveoli of the lung) hypoventilation (breathing at an abnormally slow rate, resulting in an increased amount of carbon dioxide in the blood).</p> <p>The resident had a current current physician order initially dated October 27, 2020, at 9:02 PM that the O2 tubing must be in a bag when not in use and an order initially dated October 31, 2020, at 11:00 PM to change O2 tubing, and set-up weekly night shift every Saturday, label tubing with date when changed. The resident's current physician order for oxygen, initially dated January 14, 2021, at 6:50 AM indicated that the resident was to receive, O2 therapy at 4 liters per minute (L/min) via nasal cannula, every shift, related to chronic respiratory failure with hypercapnia and COPD.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on April 16, 2024, at 11:15 AM revealed Resident 59's O2 concentrator was turned on and running, but set at 1.5 L/min not 4 liters as ordered. However, the resident was also not wearing the nasal cannula as it was observed laying on top the resident's bed. The O2 set-up nasal cannula tubing and humidification bottle was not dated, and the tubing was not in a bag while not in use failing to follow physician's orders.</p> <p>An observation on April 17, 2024, at 11:03 AM revealed Resident 59 was not receiving O2 therapy at 4 L/min via nasal cannula. The O2 set-up, nasal cannula tubing and humidification bottle, were not dated, and the nasal cannula tubing was observed on the floor, not in a bag while not in use. There was no bag observed readily available.</p> <p>A review of the resident's clinical record and current care plan revealed no documented evidence of the resident's refusal or removal of the prescribed supplemental oxygen.</p> <p>A review of clinical record revealed Resident 26 was admitted to the facility on [DATE], with diagnoses of COPD and major depressive disorder ([MDD] a mental health disorder having episodes of psychological depression [sadness]).</p> <p>The resident had a current physician order, initially dated September 29, 2022, at 12:18 PM, for O2 at 2 L/min via nasal cannula, as needed, if pulse oximetry ([SPO2] peripheral oxygen saturation, measures the amount of oxygen bound to hemoglobin in four red blood cells - normal ranges fall between 92%-100%) is less than 92%. tubing must be in a bag when not in use. The resident had also had current physician orders dated December 21, 2022, at 5:54 AM for Albuterol Sulfate nebulizer solution 2.5 milligrams (mg)/3 milliliters (ml) 0.083 %, one vial inhale by mouth every six hours as needed for COPD and an order dated September 15, 2022, at 12:05 AM for the nebulizer tubing to be kept in a bag when not in use.</p> <p>An observation on April 16, 2024, at 11:53 AM revealed Resident 26 was not receiving O2 therapy at this time. The O2 concentrator was turned on at 2 L/min. The O2 set-up nasal cannula tubing was not dated nor in a bag while not in use. The resident's nebulizer tubing and mask were not dated and was placed on top of the bedside table not in bag.</p> <p>A review of clinical record revealed Resident 124 was admitted to the facility on [DATE], with diagnoses of atrial fibrillation (a disease of the heart characterized by irregular and often faster heartbeat). The resident had a current physician order dated October 1, 2022, at 3:20 AM for O2 at 2 L/min via nasal cannula, as needed, for shortness of breath and to change nasal cannula/O2 tubing and clean concentrator and filter weekly on night shift on Saturday for infection control and as needed for infection control.</p> <p>An observation on April 16, 2024, at 11:58 AM revealed Resident 124 lying in bed receiving humidified O2 therapy via nasal cannula at 2 L/min. The O2 set-up nasal cannula tubing in use was not dated.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of clinical record revealed Resident 8 was admitted to the facility on [DATE], with diagnoses of COPD and acute and chronic respiratory failure with hypoxia. The resident had current physician's order dated November 14, 2022, at 9:46 PM to change nasal cannula/O2 tubing and clean concentrator and filter weekly for infection control and as needed for infection control and an order dated November 14, 2022, at 11:00 PM for O2 at 4 L/min via nasal cannula continuous every shift for COPD and acute and chronic respiratory failure with hypoxia.</p> <p>An observation on April 16, 2024, at 11:18 AM revealed Resident 8 lying in bed receiving humidified O2 therapy via nasal cannula at 4 L/min. The O2 set-up nasal cannula tubing and humidification bottle were not dated.</p> <p>A review of clinical record revealed Resident 64 was admitted to the facility on [DATE], with diagnoses of COPD and chronic respiratory failure with hypoxia. The resident had a current physician order dated March 22, 2024, at 4:03 AM to change the nasal cannula/O2 tubing and clean concentrator and filter weekly on night shift on Sunday for infection control and as needed for infection control and an order dated March 29, 2024, at 12:20 PM for O2 at 3 L/min via nasal cannula continuous every shift for COPD.</p> <p>An observation on April 16, 2024, at 11:18 AM revealed Resident 64 seated in her wheelchair receiving humidified O2 therapy via nasal cannula at 3 L/min. The O2 set-up nasal cannula tubing and humidification bottle were not dated to reflect when they were last changed.</p> <p>An observation on April 17, 2024, at 10:57 AM revealed Resident 64's O2 concentrator was turned on and running set at 3 L/min. The resident was not present in the room and the nasal cannula was observed laying on the floor. The O2 set-up nasal cannula tubing and humidification bottle were not dated, and the tubing was not in a bag while not in use.</p> <p>A review of clinical record revealed that Resident 48 was admitted to the facility on [DATE], with diagnoses of chronic atrial fibrillation. The resident had a current physician order dated June 11, 2023, at 10:09 PM for O2 at 2 L/min via nasal cannula as needed for SPO2 less than 90%. and an order dated June 12, 2023, at 12:17 PM to change O2 tubing and set-up weekly on 11:00 PM to 7:00 AM (night shift).</p> <p>An observation on April 16, 2024, at 11:18 AM revealed that Resident 64 was seated in a wheelchair receiving O2 therapy via nasal cannula at 2 L/min in Unit 4's sitting room. The O2 set-up nasal cannula tubing and were not dated when last changed. The oxygen cylinder tank was observed to be empty.</p> <p>An observation on April 17, 2024, at 12:42 PM revealed Resident 64 seated in a wheelchair receiving O2 therapy via nasal cannula at 2 L/min in Unit 4's sitting room. The O2 set-up nasal cannula tubing and were not dated and the oxygen cylinder tank was empty.</p> <p>Interview with the Nursing Home Administrator (NHA) on April 18, 2024, at 11:41 AM confirmed that the O2 equipment should be dated when changed/cleansed and when not being used masks and nasal cannula/nebulizer equipment should be placed in a bag when not in use.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the NHA and Director of Nursing (DON) on April 19, 2024, at approximately 1:45 PM, confirmed that the physician's order for supplemental O2 was not followed for Residents 48, 59 and 64 and O2 equipment is to be kept clean, stored properly, and that the tubing is to be changed and dated weekly.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 211.10(a)(c)(d) Resident care policies</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</b></p> <p>Based on a review of clinical records and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered plan to render trauma informed care to a resident with a diagnosis of Post-Traumatic Stress Disorder for one out of 35 residents reviewed (Resident 29).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 29 was admitted to the facility on [DATE], with diagnoses that included Post Traumatic Stress Disorder (PTSD).</p> <p>The resident's current care plan, in effect at the time of review on April 19, 2024, did not identify the resident's PTSD symptoms or triggers related to this diagnosis and resident specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization.</p> <p>The facility failed to develop and implement an individualized person-centered plan to address, this resident's diagnosis of PTSD according to standards of practice to promote the resident's emotional well-being and safety.</p> <p>Interview with the Nursing Home Administrator on April 19, 2024, at approximately 1:45 PM, confirmed the facility was unable to demonstrate that the facility provided culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing services</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39929</p> <p>Based on observations, a review of clinical records and facility investigations, and staff interview, it was determined that the facility failed to provide sufficient staff, providing direct services to residents, who possess the necessary competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as evidenced by three residents out of 35 sampled (Residents 213, 214, and 188).</p> <p>Findings include:</p> <p>Review of clinical record of Resident 213 revealed that the resident was admitted to the facility on [DATE], with diagnoses including dementia.</p> <p>A 5-Day/Admission Minimum Data Set assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated February 14, 2024, indicated that Resident 213 was severely cognitively impaired with had a BIMS (brief screener that aids in detecting cognitive impairment) score of 1. Review of Section E Behavioral Symptoms revealed multiple behavioral symptoms including Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually); Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others); Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming. Further review under section E impact on resident, indicated these behaviors significantly impacted the resident negatively and potentially impacted other residents negatively. Continued review under section E Wandering revealed the resident had wandering behavior 4-6 days during the 7 day look back period and this wondering behavior significantly impacted the privacy of other residents.</p> <p>A review of a facility investigation dated February 21, 2024, revealed Resident 213 wandered into Resident 152's room and would not leave. Resident 152 punched Resident 213 in the face. Resident 152 went to the nurses' station and informed Employee 8, LPN, that he had punched Resident 213 in the face.</p> <p>The facility investigation indicated that the resident, who was cognitively intact would be educated regarding asking for assistance if other residents wandered into their rooms. However, the underlying resident behavior which lead to the incident of abuse, Resident 213's intrusive wandering, was not addressed by the facility.</p> <p>Review of clinical record revealed Resident 213 had consistent behaviors of intrusively wandering into other residents room since admission to the facility on [DATE].</p> <p>Review of clinical record revealed Resident 214 was admitted to the facility on [DATE], with a diagnosis of latent syphilis. Review of resident record revealed repeated behaviors including consistent daily behaviors of attempting to get onto the elevator.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations of the facility's white building second floor on April 11, 2024, at approximately 9:20 a.m., revealed that Resident 214 wheeled himself onto the elevator after this surveyor got off the elevator. The resident had a wandguard to deter elopement and an alarm was triggered. No staff was observed to assist the resident off the elevator. This surveyor asked a person at the nurses' station if the resident was supposed to be on the elevator and the individual responded that they were not sure. There was no staff visible in the immediate area. A staff member was then informed and took the resident off the elevator. Further observations, as the surveyor, was at the end of the hallway with a view of the elevators, a short time later, revealed Resident 214 got back on the elevator, again setting the alarm off. After a few minutes the resident was assisted off the elevator. Staff were observed during both incidents wheeling Resident 214 off elevator and back towards the resident's room. No other interventions were observed to be employed by staff to occupy, divert or distract the resident during these incidents.</p> <p>An interview on April 18, 2024, at approximately 11:10 AM with Employee 1, CNA, confirmed that individualized diversional activities were not attempted for the residents with behaviors. Employee 1 stated that none of the residents with behaviors or dementia are provided one to one planned activities to distract or occupy them. Employee 1 stated that No one sits with them and when they are attending a group activity and begin to display any type of behavior, they are removed from the group by the activity aide and moved to the hallway for nursing staff to monitor due to disrupting the group.</p> <p>Clinical record review revealed that Resident 188 was admitted to the facility on [DATE], and had diagnoses, which included bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) and Lewy body dementia (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function).</p> <p>Resident 188's admission MDS dated [DATE], indicated that the resident had severe cognitive impairment, inattention, disorganized thinking, verbal and physical behaviors, puts others at significant risk of physical injury, intrudes on the privacy or activity of others, and wandering behavior.</p> <p>A review of Resident 188's care plan dated March 11, 2024, revealed that the resident was identified to exhibit behaviors, due to cognitive status, which included agitation, verbal outbursts, physical aggression, combativeness, stands unassisted, attempts to transfer, and attempting to hit, choke, and punch staff. Interventions included allow resident to vent thoughts and feelings, always approach in a calm, relaxed manner, encourage to express feelings, listen with empathy and non-judgmental acceptance, compassion, and ensure residents feels safe in environment.</p> <p>A nurses note dated March 15, 2024 at 6:58 PM indicated that Resident 188 was observed hitting Resident 93 on top of the head while she was being fed. The incident was observed by Employee 1 (nurse aide) who attempted to redirect the aggressor, Resident 188. Resident 188 struck Employee 1 (nurse aide) in the stomach and arms. Resident 188 was immediately redirected out of the area by staff and brought to the resident's room. The plan was to provide increased supervision per protocol. Redirect Resident 188 to high visibility areas to maintain watchful eye.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with employee 1 (nurse aide) on April 18, 2024, at 1:05 PM revealed that on the date of the incident she was feeding Resident 93 in the unit 5 (blue building third floor) dining room. At the same time, Resident 188 was also in the dining room at a table with other residents. Resident 188 was repeatedly attempting to stand from his wheelchair. Employee 1 stated that she was the only employee in the dining room at this time as other staff were passing dinner trays in the hall for residents who eat in their rooms. Employee 1 stated that Resident 188 started hanging on the table with his hands while attempting to stand and seemed to be getting aggressive. Employee 1 brought Resident 188 closer to where she was feeding Resident 93 so she could supervise Resident 188. Resident 188 stood up again and when she asked him to sit down he grabbed the back of Resident 93's wheelchair and hit her on the top of the head. Employee 1 noted that Resident 93 did not seem to realize she was hit on the head. Employee 1 stated that Resident 188 then punched her twice. Employee 1 stated that after the incident she was able to get to the nurses station for assistance.</p> <p>Interview with the Nursing Home Administrator on April 18, 2024, at approximately 2:10 PM were unable to provide evidence that the facility employed sufficient staff, with the necessary competencies and skills, sets to provide nursing and related services, to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being.</p> <p>Refer F600 and F744</p> <p>28 Pa Code 211.12 (d)(3)(4)(5) Nursing services</p> <p>28 Pa. Code 201.18 (e)(1)(3) Management</p> <p>28 Pa. Code 201.20 (a)(6) Staff development</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48277</p> <p>Based on observations, a review of select facility policy, clinical records and reports, and staff interviews, it was determined that the facility failed to develop and/or implement individualized plans to manage residents' dementia-related behavioral symptoms to promote resident safety and highest practicable physical and mental well-being for four residents out of 35 sampled (Residents 138, 213, 221 and 225).</p> <p>Findings include:</p> <p>Review of a facility policy entitled Dementia Care Services Policy with a review date of January 16, 2024, indicated that residents who are diagnosed with forms of dementia will receive the appropriate treatment and services to attain or maintain their highest practicable physical/mental/psychosocial wellbeing. Staff will demonstrate competencies and skills to support residents through the implementation of individualized approaches to care (including direct care and activities) that are focused on understanding, preventing, relieving and or accommodating a resident's distress or loss of abilities.</p> <p>Review of a facility policy entitled Behavior Management Program with a review date of January 16, 2024, indicated that the goal of the facility is to improve management of behaviors and move closer to the goal of ending any inappropriate or unnecessary use of antipsychotic medications. The facility will assess and track behavior(s) that negatively impact each resident regarding their quality of life. Upon review of data and analysis the interdisciplinary team will develop a resident specific care plan to include non-pharmacological interventions and any as needed medications. Non-pharmacological interventions will be placed on the resident's care plan and Kardex. Staff will be educated on any updates.</p> <p>Review of clinical record of Resident 213 revealed that the resident was admitted to the facility on [DATE], with diagnoses including dementia.</p> <p>A 5-Day/Admission Minimum Data Set assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated February 14, 2024, indicated that Resident 213 was severely cognitively impaired with had a BIMS (brief screener that aids in detecting cognitive impairment) score of 1.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Section E Behavioral Symptoms, of the above MDS, revealed that the resident displayed multiple behavioral symptoms including physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually); Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others); Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming. Section E, impact on resident, indicated that these behaviors significantly impacted the resident negatively and potentially impacted other residents negatively. Under section E Wandering, it was noted that the resident had wandering behavior 4-6 days during the 7 day look back period and this wandering behavior significantly impacted the privacy of other residents.</p> <p>Clinical record reviewed revealed that Resident 213 exhibited consistent wandering behaviors, including wandering into other residents' rooms, documented from the time of the resident's admission February 8, 2024, and continuing daily, culminating in an incident during which Resident 213 was physically abused by another resident as a result of Resident 213's intrusive wandering behavior on February 21, 2024. Following that incident, the facility initiated increased supervision of Resident 213, planned as 15 minute checks of the resident, However, this intervention was not effective as Resident 213 continued to repeatedly enter other residents' rooms uninvited.</p> <p>Review of Resident 213's current care plan in effect at the time of the survey ending April 19, 2024, revealed a problem area of the resident's behavioral concerns including wandering into other resident rooms. The interventions planned, however, were not individualized to this resident, not revised until after the incident on February 21, 2024, when the resident was physically abused due to this wandering behavior.</p> <p>There was no evidence that the facility had developed an interdisciplinary approach to the resident's dementia care and ensured that staff demonstrated the necessary competencies and skills to provide appropriate services to the resident, to include individualized approaches to the resident's care, including direct care and activities. There was no evidence that the facility had attempted to provide meaningful activities, which promote resident engagement based on the resident's customary routines, interests, preferences, to enhance the resident's mental health and well-being.</p> <p>An interview with the Nursing Home Administrator and Director of Nursing (DON) on April 19, 2024, at 1:35 PM, unable to provide evidence that the facility had provided this resident with an individual plan to manage the resident's dementia related behavioral symptoms.</p> <p>A review of the clinical record revealed that Resident 138 was admitted to the facility on [DATE], with diagnoses to include dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability), without behavioral disturbance (globally described as agitation, wandering, and hoarding), unsteadiness on feet.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the resident's care plan, initially dated March 11, 2022, with revision on February 15, 2024, revealed the problem of altered neurological status related to dementia with a goal that the resident will remain free of complications related to the altered neurological status. Planned interventions included, educating the family of the disease process, encouraging the resident to express feelings, maintain a regular daily schedule and routine, observe the resident for changes in memory and difficulty communicating, speak slowly using a low voice, facing the resident and call resident by name, utilize staff for Spanish speaking translation purposes.</p> <p>The resident's care plan, revised March 1, 2024, also identified the resident's wandering and that the resident suffers from dementia with a goal that the resident will be as comfortable as possible, and to provide the resident with any requested materials. Planned interventions included always using a Spanish speaking interpreter as the resident only speaks Spanish and provide the resident with a monthly activity calendar. Also the resident's care plan that was initially dated May 16, 2022, and revised on February 15, 2024, noted the problem of behaviors of agitation, delusions, verbal and physical aggression, biting kicking, pushing and hitting staff related to dementia revealed interventions in place were to approach the resident in a calm and relaxed manner, encourage activities of interest, observe and report to the nurse any behaviors, offer a room change as needed, and when exhibiting behaviors, redirect and assist in attending activities that are meaningful and of interest, such as praying and watching religious television, reapproach later if applicable.</p> <p>A significant change in condition Minimum Data Set assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated February 23, 2024, revealed that the resident was severely cognitively impaired.</p> <p>A review of a facility incident report dated March 2, 2024, at 3:45 AM revealed that the resident had an unwitnessed fall. Staff were called to find the resident lying on her stomach on the floor in another resident's room, confused at her baseline. There was a small amount of blood observed on the floor from her indwelling foley catheter being out, no signs or symptoms of pain or discomfort upon assessment. The resident was combative towards staff, attempting to bite and kick staff upon assessment. The resident stated Run in Spanish. The resident was redirected and transferred using a mechanical lift to bed and then to the chair and kept in high visible area per request. The Doctoral Nurse Practitioner (DNP) was made aware and staff planned to monitor. The immediate intervention was to keep the resident in a high visible area and conduct a sleep assessment every shift for seven days.</p> <p>A witness statement from Employee 2 (nurse aide) revealed that the resident was provided care at 2:20 AM and that Employee 2 did not witness Resident 138 fall as she was on her lunch break at the time of the incident. When returning from lunch, a call bell was ringing from another resident room and as Employee 2 was going to answer the call bell, walking down the hall, observed Resident 138 on the floor in another resident's room and then notified the nursing staff on duty.</p> <p>A Fall Risk Evaluation - V1 dated March 2, 2024, at 4:45 AM revealed that the resident has had one to two falls in the past 90 days. The resident displayed the following behaviors: easily distracted, periods of altered perception or awareness of surroundings, episodes of disorganized speech, periods of restlessness, periods of lethargy, mental function varies over the course of the day, wanders and is abusive and resists care. The resident is independent and incontinent of going to the bathroom and ambulates with problems and with devices (i.e., unsteady, slow, lurching), not steady and only able to stabilize with physical assistance. A physical and occupational therapy referral was placed related to this fall.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A progress note dated March 3, 2024, at 2:43 AM revealed that neurological checks continued as ordered and were within normal limits, vital signs stable, out of bed to wheelchair this shift with increased restlessness at times, one to one, fluids and snacks provided. The resident attempted to hit staff when attempts were made to redirect.</p> <p>There was no evidence that the care planned interventions identified in the resident's plan of care for responding to the resident's behaviors were consistently implemented in an attempt to distract or divert this resident's attention and behaviors.</p> <p>A review of a facility incident report dated March 28, 2024, at 2:58 AM revealed that the resident was observed to be digging her nails into her skin causing an opening in her middle finger left hand. The resident's nails were found to be long, no contractures in the hand were noted. The resident was recently provided pain management and vital signs were stable. Resident was unable to give description of the incident. Immediate action taken was to provide care to the area. The resident was responsive and combative. There was no evidence that interventions established in the resident's care were implemented to divert or distract this resident from the self-injurious behaviors.</p> <p>A review of progress notes dated March 24, 2024, at 3:38 AM revealed that the resident was awake and out of bed throughout the night yelling loudly at times and attempting to stand unassisted, becoming combative when attempts were made to redirect. Fluids were provided and the resident squeezed the cup, spilling the fluids all over. The resident was placed in the television (TV) lounge to watch TV (television program not specified)</p> <p>Observations on April 16, 2024, at approximately 10:06 AM and again on April 18, 2024, at approximately 9:00 AM revealed that resident was seated in a Broda chair (a wheelchair that reclines and provides comfort, support, and mobility) in the hallway near the nurse's station by herself. The resident was confused and was unable to communicate. The resident was not provided any diversional activities as outlined in the resident's dementia care plan at the time of these observations.</p> <p>A review of progress notes dated April 17, 2024, at 9:38 AM revealed that the resident was rejecting care including refusing to be seen by the in-house dentist, becoming combative toward the dental team. Social services will continue to encourage compliance to said refusal and will monitor.</p> <p>An interview on April 18, 2024 at 11:10 PM with Employee 1 (nurse aide) also verified that individualized diversional activities were not provided as care planned for Resident 138. Employee 1 stated that none of the residents with behaviors or dementia have one-to-one planned diversional activities to distract or occupy them. Employee 1 stated that No one sits with them and when they are attending a group activity and begin to display any type of behavior, they are removed from the group by the activity aide and moved to the hallway for nursing staff to monitor the resident because they are disrupting the group activity.</p> <p>There was no documented evidence to demonstrate that facility staff had implemented the specific interventions planned to manage the resident's dementia related behaviors, including providing specific individualized diversional activities and care as outlined in the resident's plan of care in response to the behaviors displayed by the resident.</p> <p>A review of the clinical record revealed that Resident 221 was admitted to the facility on [DATE], with diagnoses to include dementia with other behavioral disturbance.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident's care plan, initially dated December 8, 2023, and revised on April 1, 2024, for impaired cognitive function or thought processes indicated that the resident is at risk of behaviors and/or mood issues. The goal was that the resident will have no behaviors and maintain behavioral manifestation to a minimum with planned interventions to encourage the resident to express feelings of anger, sadness or guilt and help to come up with alternative ways to handle feelings, establish trust offering unconditional acceptance, maintain a calm, non-threatening manor while working with the resident, provide reassurance and comfort measures, refer to psychiatric services and use short, simple directions. The care plan dated December 11, 2023, for altered neurological status related to Dementia noted a goal that the resident will remain free of complications related to the altered neurological status. Planned interventions included encouraging the resident to express feelings, maintain a regular daily schedule and routine, observe the resident for changes in memory and difficulty communicating, speak slowly using a low voice, facing the resident and call resident by name.</p> <p>A quarterly MDS dated [DATE], revealed that the resident was severely cognitively impaired.</p> <p>A progress note dated April 11, 2024, at 10:11 AM revealed that the resident displayed verbal behaviors including yelling/screaming and verbal aggression towards staff and roommate. She was encouraged to be respectful to her roommate, and no mood concerns at present time, will continue to monitor.</p> <p>A review of a facility investigation dated April 12, 2024, at 1:24 AM revealed that staff heard yelling from the resident's room. Upon entering the room, staff observed Resident 221 attempting to remove a shirt from another resident that was sitting on the bed, telling that resident, that it was her shirt. Staff separated the residents. Resident 221 stated she is going through my stuff; she is going to end up eating everything. The resident was assessed to have a superficial scratch on her chest measuring approximately 4.5 centimeters (cm) long. She also stated the other resident broke her necklace. She was placed on increased supervision.</p> <p>A further review of progress notes dated April 12, 2024, at 1:36 AM revealed that during the altercation when Resident 221 forcefully attempted to remove a shirt from her roommate, her roommate stated that she got me real good with those knuckle punches and pointed to her head.</p> <p>There was no documented evidence at the time of the survey ending April 19, 2024, to demonstrate that facility had updated the resident's care plan with respect to the resident's dementia related behaviors to plan for implementation of specific person centered interventions to respond to the resident's behaviors, in an effort to deter, modify or safely manage the behaviors displayed.</p> <p>A review of Resident 225's clinical record revealed admission to the facility on [DATE], with diagnoses to include dementia with other behavioral disturbances (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change), and paranoid schizophrenia (a severe mental health disorder in which a person interprets reality abnormally, experiencing hallucinations, delusions, and extremely disordered thinking and behaviors).</p> <p>An admission Minimum Data Set assessment (a federally mandated standardized assessment completed periodically to plan resident care) dated February 9, 2024, indicated that the resident was severely cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a progress note dated March 27, 2024, at 1:51 PM indicated that the resident was wandering in other residents' rooms and staff provided redirection, but did not identify the measures used to redirect the resident's behaviors at that time.</p> <p>A progress note dated March 29, 2024, at 4:56 PM revealed that the resident was on increased supervision due to wandering into other residents' rooms. Redirection was provided, and alternate activities/snacks/fluids and 1:1 interaction were effective.</p> <p>A review of a progress note dated March 31, 2024, at 9:48 PM revealed that the resident was roaming the halls and getting into other resident's rooms and redirection was provided.</p> <p>A progress note dated April 1, 2024, at 2:55 PM revealed that the resident was wandering in the hall and behind the nurses station. Redirection was provided multiple times and increased supervision continued.</p> <p>A review of a progress note dated April 2, 2024, at 5:14 AM revealed that the resident was roaming outside her bedroom, undressed. Resident dressed and redirected back to bedroom.</p> <p>A review of a progress note dated April 5, 2024, at 2:45 PM revealed resident wandering in and out of other residents' rooms. Redirection was provided.</p> <p>A review of a progress note dated April 7, 2024, at 11:51 AM revealed that resident had increased behaviors, going in and out of residents rooms and touching other residents belongings. Redirection was attempted however unsuccessful. There was no documented evidence of the interventions attempted, and proved unsuccessful in diverting the resident's behaviors at that time, to review and revise the resident's dementia care plan.</p> <p>A progress note dated April 18, 2024, at 4:55 AM revealed that the resident was awake most of the shift and staff were unable to redirect the resident. The resident was yelling aloud to staff and wandering in other residents' rooms. Staff offered food/fluids, which were ineffective.</p> <p>A review of a progress note dated April 19, 2024, at 7:02 AM revealed that the resident was awake all shift and would not lay in bed. The resident was disrobing at times and yelling aloud. Food/fluids, toileting and back rub provided. Effectiveness these interventions were not noted.</p> <p>The resident's current care plan, in effect at the time of the survey ending April 19, 2024, did not identify the resident's specific behaviors of intrusive wandering the resident had been exhibiting due to her dementia diagnosis and the development of specific individualized interventions for staff to employ to address this dementia-related behavior.</p> <p>The facility failed to develop and implement an individualized person-centered plan to address, modify and manage, to the extent possible, this resident's dementia-related behaviors. The resident's care plan for behavioral symptoms failed to include individualized interventions based on an assessment of the resident in an effort to manage the resident's dementia-related behavioral symptoms.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Nursing Home Administrator on April 19, 2024, at approximately 1:30 PM, confirmed the facility was unable to provide evidence of the development and/or implementation of an individualized person-centered plan to address dementia-related behaviors. The facility also failed to demonstrate timely and consistent efforts to implement a person-centered individualized dementia-related care plan to address the residents' ongoing behaviors and minimize, modify, or manage dementia-related behaviors.</p> <p>Refer F600</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 211.10 (a)(d) Resident care policies</p> <p>28 Pa. Code 201.29 (a) Resident rights</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41581</p> <p>Based on a review of clinical records and staff interviews it was determined that the facility failed to ensure that residents were free from significant medication errors for one resident out of (Resident 103) out of 35 sampled.</p> <p>Findings included:</p> <p>A review of the clinical record review revealed that Resident 103 was admitted to the facility on [DATE], with diagnoses of unspecified psychosis, and dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain) with agitation.</p> <p>Resident 103 had a physician order, initially dated February 22, 2024, for risperidone (antipsychotic drug) tablet 0.25 mg give one tablet in the evening, and a physician order, initially dated March 14, 2024, for Asenapine (antipsychotic drug) transdermal patch 3.8 mg/24 hours, apply one patch transdermal at bedtime when available; discontinue the risperidone.</p> <p>A review of Resident 103's March 2024 Medication Administration Record (MAR) revealed that on March 15, 2024, the physician prescribed Asenapine patch was available for administration to the resident and applied at 8:00 PM, and daily thereafter as ordered.</p> <p>However, further review of the resident's March 2024 MAR revealed that nursing staff also continued to administer risperidone 0.25 mg to the resident from March 15, 2024, through March 26, 2024, despite the physician's order to discontinue the risperidone .25 mg when the Asenapine patch was available.</p> <p>Nursing staff administered 12 additional daily doses of the antipsychotic drug risperidone .25 mg, when the medication should have been discontinued per physician orders.</p> <p>During an interview April 19, 2024, at approximately 1:45 PM the Director of Nursing and Nursing Home Administrator confirmed that nursing staff failed to follow physician orders for accurate medication administration resulting in a medication error, whereas Resident 103 received 12 doses of risperidone after it was discontinued by the physician.</p> <p>28 Pa. Code 211.9 (a)(1)(d) Pharmacy services</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing 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 - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>21738</p> <p>Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department and one of five resident pantries.</p> <p>Findings include:</p> <p>Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food).</p> <p>Review of the facility policy titled Food Brought in from Outside the Facility last reviewed by the facility January 16, 2024, indicated that food brought in from an outside source will be stored in a clean, sealed container. The container will be labeled with the name of the food item, the resident name, dated. Food dated by facility staff will be discarded within seven days from the date mark. The refrigerator will be cleaned routinely.</p> <p>The initial tour of the kitchen was conducted with the facility's foodservice directors and Registered Dietitian (RD) on April 16, 2024, at 9:25 AM, revealed unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness</p> <p>The following was observed during a tour of the blue building's kitchen area on April 16, 2024, at 9:25 AM:</p> <p>There were four large garbage cans which were visibly soiled with a heavy accumulation of food spills adhered to the exterior surface of the garbage cans.</p> <p>Two of six hood vents located above the stove area had a thick accumulation of dust.</p> <p>There was a thick layer of dust on the fins of the filter of the ice machine.</p> <p>There was plastic container of powdered milk with a plastic cup stored inside (being used as a scooper).</p> <p>There were multiple plastic pitchers stored on a shelf and identified as clean which were visible soiled with iced tea stains.</p> <p>Also stored on the shelf were multiple pitchers with a heavy build-up of adhesive label residue.</p> <p>There was a build-up of dirt on the floor of the dry storage room.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>There was a thick build-up of dirt, spills, and food stains along the front and bottom shelf of the stainless-steel table located in the dishroom.</p> <p>There was a black colored substance adhered to the plastic lid of a 5 gallon container of chemical sanitizer connected to the three-compartment sink.</p> <p>The floor basin located in the janitor closet was heavily soiled had a build-up of debris in the drain.</p> <p>Interview with the foodservice director and RD at the time of these observations confirmed that the food and nutrition services department was to be maintained in a sanitary manner to prevent food contamination.</p> <p>The following was observed during tours of the white building's kitchen area on April 16, 2024, at 10:00 AM:</p> <p>There was a one pound block of margarine and plastic container of solidified melted margarine stored on the shelf in the cook's area. The manufacturer label on the margarine noted the margarine was to be kept refrigerated.</p> <p>There was an approximate six inch missing section of wall above the floor basin located in the janitor closet.</p> <p>Observation of the resident food pantry located on the third floor of the Blue building on April 16, 2024, at 12:15 PM, revealed that inside the refrigerator there was an opened 15-ounce bottle of strawberry banana juice without a name or date, a bag containing two lemons, an apple and a jar of cayenne pepper without a name or date, a bag containing two boxes of Tastycake donuts without a name or date, two 5-ounce cartons of nutritional juice drink that lacked a thaw date or discard date (manufacturer's label noted that the drinks were to be used within 14 days of thawing). A red substance was spilled on the shelving and in the fruit drawer of the refrigerator.</p> <p>Interview with Employee 9 (licensed practical nurse) on April 16, 2024, at 12:26 PM confirmed the observations of the third-floor resident food pantry.</p> <p>Interview with the Nursing Home Administrator on April 18, 2024, at approximately 1:00 PM confirmed that the food in the resident pantry was to be labeled and dated and that the dietary department was to be maintained in a sanitary manner.</p> <p>28 Pa. Code 211.6 (f) Dietary services.</p> <p>28 Pa. Code 201.18 (e) (2.1) Management</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>21738</p> <p>Based on a review of clinical records, select facility policies, investigate reports, and employee job descriptions it was determined the facility's administration failed to effectively use its resources to promote resident safety by failing to implement established procedures to prevent physical abuse of six out of 41 sampled residents (Residents 212, 93, 203, 178, 487, and 213).</p> <p>Findings include:</p> <p>A review of a facility policy entitled Pennsylvania Resident Abuse: Abuse, Neglect, and Exploitation, dated August 30, 2023, revealed that it is the policy of the facility to not tolerate abuse, neglect, mistreatment, exploitation of residents, or misappropriation of resident property by anyone. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>A review of facility reports and clinical records between January 1, 2024, and the time of the survey ending April 19, 2024, revealed that the facility failed to protect Residents 212, 93, 203, 178, 487, and 213 from physical abuse, perpetrated by other residents.</p> <p>A review of the job description for the Administrator of the facility revealed that the Administrator leads and directs the overall operations of the facility in accordance with community policies and procedures, customer, and resident needs, and both state and federal guidelines. To maintain excellent care for the residents/patients and achieve the facility's business objective. The administrator is delegated the administrative authority, responsibility, and accountability for carrying out assigned duties. Responsible for carrying out the operational core responsibilities established by the company and the facility. Responsible for oversight of the resident care policies established by the facility. Essential functions, duties, and responsibilities include: monitoring each department's activities, ensuring that each department attains and maintains compliance with state and federal requirements, rounds frequently throughout the facility to monitor the delivery of nursing care, overall cleanliness and appearance of the facility, develops an environment where positive and creative thinking helps solve problems, and meets regularly with the residents of the facility to ensure they are satisfied with the delivery of care, ensures that company consultants and other support resources are appropriately utilized and a high level of interdepartmental teamwork is maintained, hold monthly all staff meetings, and meet at least quarterly with staff on evening and night shift.</p> <p>A review of the job description for the Director of Nursing (DON) indicated that under the supervision of the administrator, the DON is to organize, develop, and direct the overall operations of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines and regulations that govern the facility. The DON is to work directly with the Administrator and Medical Director to ensure the highest degree of quality of care is maintained for each resident at all times.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON plans, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the nursing care facilities. Ensure nursing personnel have completed orientation, competencies, and perform annual and periodic evaluations. Responsible for the daily calculation of the direct nursing care personnel on duty each shift. Maintain a master schedule to enhance staffing and enable an accurate need for staffing at all times. Monitor nursing care to ensure all residents are treated fairly and with kindness, dignity, and respect. Participate in interviewing and selection of residents for admission. Responsible to complete daily rounds of the facility with the administrator. Responsible in developing a written comprehensive care plan to meet the nursing needs of each resident. Encourage the resident and his/her family to participate in the development and review of the resident's plan of care. Ensure all personnel are involved in providing care to the resident in accordance to the plan of care. Responsible for maintaining staffing levels to comply with the 5-Star review.</p> <p>The deficiency cited under the Code of Federal Regulatory Groups for Long Term Care, Freedom from Abuse, Neglect, and Exploitation (F600) 483.12(a)(1) each resident has the right to be free from abuse, neglect and corporal punishment of any type by anyone, revealed that the Administrator and DON failed to fulfill the essential job duties for ensuring the health and safety of the residents and adherence to regulatory guidelines.</p> <p>Refer F600</p> <p>28 Pa. Code: 201.12 (a) Responsibility of licensee</p> <p>28 Pa. Code: 201.18 (b)(1)(e)(1) Management</p> <p>28 Pa. Code:211.12(c) Nursing Services</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>21738</p> <p>Based on staff interviews and a review of the facility's assessment and the medical, psychiatric, and mental health conditions of the resident census it was determined that the facility failed to conduct and document a facility wide assessment, which identified the specific resources necessary to care for its specific resident population.</p> <p>Findings include:</p> <p>At the time of the survey ending April 19, 2024, the facility had completed a facility assessment to determine the specific and unique needs of its resident population.</p> <p>Following surveyor inquiry, the facility provided a Facility Assessment document last reviewed January 9, 2024, which identified that the facility's average daily census was 232 residents. The number/average or range of residents with behavioral health needs was 20 to 30.</p> <p>A review of facility documentation as of the date of the survey ending April 19, 2024, revealed that there were 73 residents with Alzheimer's disease/dementia and 54 residents with a mental disorder, intellectual disability, or related condition.</p> <p>Review of facility documentation revealed that there were seven incidents of resident-to-resident abuse between January 1, 2024, and April 19, 2024.</p> <p>The Facility Assessment failed to accurately reflect the current population in the facility and the behavioral health and dementia care needs of the residents to ensure resident safety and that residents remained free from physical abuse.</p> <p>The facility assessment presented to the survey team did not include comprehensive data and corresponding resources in order to competently care for the current behavioral health care needs and dementia related behavioral care of the resident population in the facility.</p> <p>Refer F600, F741, F744</p> <p>28 Pa. Code 201.18 (b)(3) Management</p>