

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/18/2025
NAME OF PROVIDER OR SUPPLIER  Mount Carmel Senior Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE  2616 Locust Gap Highway MT Carmel, PA 17851	

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 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**</b> 36798</p> <p>Based on observation and staff interview, it was determined that the facility failed to provide a clean, comfortable, and homelike environment on four of four nursing units reviewed ([NAME]; Oak: Resident 6; Marble: Resident 3; and Maple: Resident 1).</p> <p>Findings include:</p> <p>Observation on March 18, 2024, at 8:30 AM of the [NAME] nursing unit shower room revealed rust around the two doors to the left as you entered the shower room. The second door to the left as you entered the shower room was warped and splintered at the bottom. The floor had a brown substance and loose particles of dirt on it. The first shower stall had a black substance on the floor of the shower and on the wall tiles, and two shower chairs located in this stall were dirty around the base.</p> <p>The second shower stall had a black substance on the floor and wall tiles, the shower curtain was dirty around the bottom, and ripped, two shower chairs located in the stall were dirty, grab bars in the shower were noted to have rust on them, and the drain in the floor appeared to have hair build up on top of it.</p> <p>The third shower stall had a black substance on the floor and wall tiles, the cove base was dirty, the grab bars had rust on them, and a shower gurney that was in this stall was dirty. The floor was dirty under the wall sink, the cove base under the sink was dirty, the faucets around the sink were dirty, and there was a candy wrapper and a clump of hair in the sink. The dirty linen bins in the shower room were dirty around the base and on the handle. The bin labeled trash was dirty around the base. The curtains around the tub were dirty. The toilet was dirty around the base and behind it. There was a bucket on the floor to the left of the toilet (when you are looking at the toilet) that had a brown substance in it.</p> <p>Observation of Resident 6's room on March 18, 2025, at 8:08 AM revealed her overbed table was dirty around the base, the foot board under her bed was noted with black areas on the floor, loose dirt particles in front of the closet and bathroom door, and beside her dresser and nightstand. The privacy curtain located between the beds was dirty with brown areas.</p> <p>Observation of the same shower room and Resident 6's room, on March 18, 2024, at 3:12 PM with the Nursing Home Administrator and Employee 1, Assistant Director of Nursing, confirmed the above noted findings.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of Resident 3's room on March 18, 2025, at 8:14 AM revealed a box of instant coffee stored on the floor. The area under Resident 3's bed contained two baskets, a box, and six scattered slipper socks. The tabletop on the left side of Resident 3's bed stored a stack of loose papers and envelopes over approximately one foot high, an opened individual package of crackers, several clear unlabeled and undated sandwich-sized bags of chips and goldfish crackers, and hygiene items (e.g., deodorant). The amount and organization of Resident 3's personal items rendered those areas inaccessible to effective housekeeping services.</p> <p>Observation of Resident 1's room on March 18, 2025, at 8:51 AM revealed smearing of a brown substance, eight to 12 inches long by several inches wide, on the floor on the left side of her bed.</p> <p>Observation of Resident 1's room on March 18, 2025, at 10:40 AM and 12:54 PM revealed that the brown substance remained on the floor.</p> <p>Observation of Resident 1's room on March 18, 2025, at 1:12 PM revealed that the brown substance remained on Resident 1's floor; however, was now approximately six inches in length. Staff stood on the left side of Resident 1's bed to assist her with eating her lunch.</p> <p>Interview with Employee 3 (housekeeping) on March 18, 2025, at 1:16 PM confirmed that she was done providing services to the rooms on the Maple hallway. The surveyor made Employee 3 aware of the brown smearing on Resident 1's floor. Employee 3 utilized a wet mop to remove the substance from the floor at that time. Employee 3 stated that she may not have mopped that side of Resident 1's room if staff were present when she provided housekeeping services to that room.</p> <p>The above noted concerns related to the environment were reviewed with the Nursing Home Administrator and Employee 1 during a meeting on March 18, 2025, at 4:20 PM.</p> <p>28 Pa. Code 201.18(e)(2.1) Management</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20725</p> <p>Based on a review of select facility policies and procedures, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to provide the highest practicable care regarding bowel protocol medication administration for three of seven residents reviewed (Residents 1, 2, and 4); and physician ordered blood sugar assessments and insulin administration for five of nine residents reviewed (Marble hallway: Residents 3, 7, and 8; Maple hallway: Resident 5; and [NAME] Hallway: Resident 4) resulting in hypoglycemia and hospitalization for one of nine residents reviewed (Maple hallway: Resident 1).</p> <p>Findings include:</p> <p>The facility policy entitled, Bowel Protocol, last reviewed January 17, 2025, revealed that the following protocol will be used for assessing all residents for constipation. Responsibility for this protocol is as follows: 3:00 PM - 11:00 PM shift runs bowel movement list from care tracker at the start of their shift and gives medications as appropriate. Results are to be followed up as per protocol on the next shift. The following protocol is to be ordered on admission unless the doctor specifies otherwise (renal patients will need alternate bowel management ordered by the physician):</p> <ol style="list-style-type: none"> <li>1. MOM (Milk of Magnesia, a liquid laxative medication) 30 ml (milliliters) by mouth every three days on 3:00 PM to 11:00 PM shift if no bowel movement</li> <li>2. Dulcolax suppository (laxative medication administered rectally) 10 milligrams (mg) rectally every fourth day on 3:00 PM to 11:00 PM shift if MOM ineffective</li> <li>3. Fleet enema (liquid laxative medication administered rectally) rectally every fifth day if Dulcolax ineffective or no bowel movement</li> <li>4. Notify physician if bowel regime is ineffective for bowel movement</li> </ol> <p>Bowel Protocol for renal patients:</p> <ol style="list-style-type: none"> <li>1. Dulcolax tablets give one tablet every three days on 3:00 PM to 11:00 PM shift if no bowel movement</li> <li>2. Dulcolax suppository (10 mg) rectally every fourth day on 3:00 PM to 11:00 PM shift if ineffective or no bowel movement</li> <li>3. Give soap suds enema (combination of distilled water and a small amount of soap administered rectally to irritate the bowels and stimulate a bowel movement), one, rectally, every fifth day if Dulcolax suppository ineffective, give on 11:00 PM to 7:00 AM shift</li> <li>4. Notify physician if bowel regime is ineffective for bowel movement</li> </ol> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Clinical record review for Resident 1 revealed physician orders for staff to administer a Bisacodyl (Dulcolax) 5 mg tablet as needed for constipation, give if there is no bowel movement by the third day on evening shift.</p> <p>Review of Resident 1's bowel movement records revealed that staff documented no bowel movement on March 1, 2, or 3, 2025.</p> <p>Resident 1's MAR (Medication Administration Record, electronic documentation of medication administration) dated March 2025 revealed that staff did not administer the Bisacodyl 5 mg tablet to Resident 1 on the evening shift day of the third day without a bowel movement.</p> <p>Clinical record review for Resident 2 revealed physician orders for staff to administer one enema rectally as needed for no bowel movement, administer on the 11:00 PM to 7:00 AM shift for no bowel movement for five days. The physician's order did not indicate if staff were to administer a Fleet enema or a soap suds enema. Resident 2's physician orders instructed staff to administer a Dulcolax 5 mg tablet every 24 hours as needed for constipation and a Dulcolax 10 mg rectal suppository as needed on the 3:00 PM to 11:00 PM shift for no bowel movement on the fourth day of no bowel movement.</p> <p>Review of Resident 2's bowel movement records revealed that staff documented no bowel movements on February 19, 20, 21, 22, 23, and 24, 2025.</p> <p>Review of Resident 2's MAR dated February 2025 revealed no evidence that staff administered any Dulcolax medications or enemas when Resident 2 failed to have bowel movements for four and five days.</p> <p>The surveyor reviewed the above concerns regarding the staff failure to administer Resident 1's and Resident 2's physician ordered laxative medications appropriately during an interview with the Nursing Home Administrator and Employee 1 (assistant director of nursing) on March 18, 2025, at 4:00 PM.</p> <p>Clinical record review for Resident 4 revealed that she did not have a bowel movement on February 20, 21, 22, or 23, 2025.</p> <p>Further clinical record review revealed physician orders for staff to administer Dulcolax tab 5 milligrams as needed if no bowel movement times three days and Bisacodyl suppository 10 mg give one suppository rectally as needed for constipation every fourth day on the evening shift if the Dulcolax oral tab is ineffective.</p> <p>Review of Resident 4's MAR revealed that she received Dulcolax tab 5 milligrams on February 22, 2025, at 5:46 PM, and it was documented as ineffective. There was no evidence in the clinical record that Resident 4 received the Bisacodyl suppository on the evening of the fourth day of no bowel movement.</p> <p>The facility failed to follow the physician ordered bowel protocol for Resident 4.</p> <p>The surveyor reviewed the above concerns regarding the staff failure to administer Resident 4's physician ordered bowel protocol appropriately during an interview with the Nursing Home Administrator and Employee 1 (assistant director of nursing) on March 18, 2025, at 4:15 PM.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy entitled, Medication Administration - General Guidelines, last reviewed January 17, 2025, revealed that medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Medications are administered within 60 minutes of the scheduled time, except before or after meal orders, which are administered based on mealtimes. These orders, including blood sugar finger sticks (collection of a drop of blood from a fingertip needle prick onto a test strip and read by a medical meter device; normal ranges per Cleveland Clinic 70 to 99) must be completed within 30 minutes of the scheduled mealtime.</p> <p>Review of the facility's posted, Meal Service Times, revealed the following anticipated schedule for the breakfast meal:</p> <p>[NAME] hallway 7:05 AM</p> <p>Marble hallway 7:15 AM</p> <p>Oak hallway 7:25 AM</p> <p>Maple hallway 7:35 AM</p> <p>Interview with Employee 2 (licensed practical nurse, LPN) on March 18, 2025, at 7:35 AM, revealed that no breakfast trays arrived on either the Marble or Maple hallways. Further interview with Employee 2 revealed that the third shift LPN obtained a finger stick assessment for Resident 7 (who resided on the Marble hallway) at 6:21 AM.</p> <p>Interview with Resident 7 on March 18, 2025, at 7:57 AM, revealed that staff typically obtain a finger stick assessment between 5:30 AM and 6:00 AM (approximately more than an hour before the anticipated time of the arrival of her breakfast meal).</p> <p>Interview with Employee 2 on March 18, 2025, at 7:35 AM, revealed that the third shift LPN obtained a finger stick assessment for Resident 8 (who resided on the Marble hallway) at 6:22 AM.</p> <p>Observation of Resident 8 on March 18, 2025, at 8:11 AM (almost two hours after his finger stick assessment), revealed him to be in bed without a breakfast meal.</p> <p>Interview with Employee 2 on March 18, 2025, at 7:35 AM, revealed that the third shift LPN obtained a finger stick assessment for Resident 3 (who resided on the Marble hallway) at 6:25 AM; however, she did not receive insulin in response to her finger stick assessment of 144.</p> <p>Clinical record review for Resident 3 revealed active physician orders for staff to administer:</p> <p>Novolog mix 70/30 insulin (hormone injected to lower blood sugar; combination intermediate-acting insulin, the combination insulin starts to work within 10 to 20 minutes after injection, peaks in two hours, and keeps working for up to 24 hours) inject 24 units one time a day</p> <p>Fiasp (Insulin Aspart (with Niacinamide), hormone injected to lower blood sugar) inject as per sliding scale before meals and at bedtime</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 3's MAR (Medication Administration Record, documentation by licensed staff of the administration of medications) dated March 2025 revealed that the facility scheduled Resident 3's Fiasp medication daily at 6:30 AM (three-quarter hours before the anticipated delivery time of the Marble hallway breakfast meal) and the Novolog mix 70/30 insulin at 6:00 AM (more than one and one-quarter hours before the anticipated delivery time of the Marble hallway breakfast meal). Review of the medication administration documentation revealed that staff administered Resident 3's Novolog mix 70/30 insulin on March 18, 2025, at 6:24 AM (more than one hour before the delivery of her breakfast meal).</p> <p>The medication resource, Drugs.com, stipulated that when using Novolog mix 70/30 insulin, it is important to time your insulin use with meals. You should use this medicine within 15 minutes before or after the start of a meal. The same resource indicated that Fiasp insulin should be taken with the meal or within 20 minutes after.</p> <p>Interview with Employee 2 on March 18, 2025, at 8:32 AM, confirmed that the third shift licensed nursing staff administer Resident 3's morning insulin doses daily as needed because first shift licensed nursing staff would not have time to administer the medications due to the time their shift starts and the requirement to obtain verbal report for the shift.</p> <p>Resident 1's clinical record revealed that she had a diagnosis of Type 2 diabetes mellitus (a chronic condition characterized by insulin resistance and elevated blood sugar levels) with diabetic neuropathy (nerve damage that can occur when you have diabetes).</p> <p>Interview with Employee 5 (LPN) on March 18, 2025, at 7:50 AM, revealed that Resident 1 (who resided on the Maple hallway) did not have a breakfast tray yet because she lived on the hallway that received meals from the last food cart.</p> <p>Clinical record review of Resident 1's MAR dated March 2025, revealed that Employee 4 (LPN) administered 44 units of Lantus SoloStar insulin (a long-acting insulin that starts to work several hours after injection) on March 7, 2025, at 5:50 AM (one hour and 45 minutes before her anticipated breakfast meal). Employee 4 also administered two units of Insulin Aspart insulin (brand names of Fiasp or Novolog; a fast-acting insulin that starts to work about 15 minutes after injection and peaks in about one hour) on March 7, 2025, at 5:50 AM, for Resident 1's finger stick blood sugar assessment of 139.</p> <p>The medication resource, Drugs.com, stipulated that when using insulin aspart, after using Novolog, you should eat a meal within five to 10 minutes. Fiasp should be given at the start of a meal or within 20 minutes after starting a meal.</p> <p>Nursing documentation dated March 7, 2025, at 8:45 AM, revealed that staff found Resident 1 grunting, with her tongue, hanging out, she was unable to follow commands, and she was unable to swallow. Staff assessed her finger stick blood sugar assessment as 31 (normal 70 to 99). Staff administered intramuscular glucose (Glucagon injection, a hormone medication used to treat very low blood sugar (hypoglycemia).</p> <p>Nursing documentation dated March 7, 2025, at 11:35 AM, revealed that the facility called 911 (emergency medical response); and nursing documentation dated March 7, 2025, at 12:04 PM, revealed that the 911 medics transported Resident 1 to the hospital emergency room .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's hospital discharge summary for her admission from March 7 to 10, 2025, revealed that the principal diagnosis for her stay was hypoglycemia. The documentation stipulated that the facility sent Resident 1 for evaluation of hypoglycemia and unresponsiveness. Per nursing home, they state that upon awakening this AM, her blood glucose was 32. She was given glucagon and glucose gel (over-the-counter medication used for hypoglycemia to raise the blood sugar when it becomes dangerously low) as well as breakfast however following breakfast her blood glucose was only 70 and the it (sic) was 31 around recheck at 11:30 AM. She was started on D5NS (intravenous fluid that contains a combination of a sugar and a salt to provide water, electrolytes, and calories) for her blood sugars. Resident 1, was admitted to the hospital due to hypoglycemic episode at skilled nursing facility with lows down to 32.</p> <p>Review of Resident 1's meal intake percentage for March 7, 2025, revealed that nurse aide staff documented at 9:48 AM that Resident 1 refused breakfast (which would not have arrived until more than one and one-half hour after her insulin administration).</p> <p>Interview with Employee 5 on March 18, 2025, at 7:50 AM, revealed that Resident 5 (who resided on the Maple hallway) did not have a breakfast tray yet. Employee 5 stated that the third shift LPN obtained a finger stick assessment for Resident 5 on March 18, 2025, at 6:30 AM (almost one and one-half hour earlier).</p> <p>Interview with Resident 5 on March 18, 2025, at 8:54 AM, revealed that staff obtain her morning finger stick blood sugar assessment around 6:00 AM every morning. Resident 5 stated that she received insulin at the time staff performed her finger stick that morning. Observation of Resident 5's breakfast meal tray on the date and time of the interview revealed that she did not eat more than 50 percent of her meal. Resident 5 stated that she ate, a piece of sausage.</p> <p>Clinical record review for Resident 5 revealed physician orders for staff to administer 12 units of insulin aspart with</p> <p>meals. Parameters included in the physician's order instruct staff to not give the medication when the blood sugar is less than 110 or poor oral intake (of food).</p> <p>Review of Resident 5's MAR dated March 2025 confirmed that staff documented the administration of Resident 5's insulin aspart on March 18, 2025, at 6:28 AM (more than one and one-half hours before the anticipated delivery time of her breakfast meal).</p> <p>The surveyor reviewed the above concerns regarding the scheduling of insulin administrations in relation to the anticipated breakfast meal delivery service during an interview with the Nursing Home Administrator and Employee 1 (assistant director of nursing) on March 18, 2025, at 4:00 PM.</p> <p>Observation on the [NAME] hallway on March 18, 2025, at 7:38 AM revealed staff starting to distribute breakfast trays to residents. Resident 4 received her breakfast tray at 7:43 AM. Interview of Resident 4 at 7:45 AM revealed that she receives insulin, and they monitor her blood sugar. She indicated that she had her blood sugar and insulin about an hour ago. She said her blood sugar was high, but she did not remember how high it was.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Clinical record review of Resident 4's MAR dated March 2025 revealed physician orders for staff to administer 10 units of NovoLog insulin meals and she also had an order for NovoLog to be administered with coverage (insulin provided by a scale that is determined by what the blood sugar was) before meals and at bedtime. Her coverage parameters were as follows: 150-200- 2 units, 201-250- 4 units, 251-300- 6 units, 301-350- 8 units, 351-400- 10 units, and above 400 give 10 units and recheck the blood sugar in two hours.</p> <p>Further clinical record review revealed that Resident 4's NovoLog insulin, her blood sugar and her coverage were all documented that they were done at 6:30 AM, one hour and 13 minutes prior to Resident 4 receiving her breakfast.</p> <p>The surveyor reviewed the above concerns regarding the scheduling of insulin administrations in relation to the time Resident 4 received her breakfast meal during an interview with the Nursing Home Administrator and Employee 1 (assistant director of nursing) on March 18, 2025, at 4:20 PM</p> <p>483.25 Quality of Care</p> <p>Previously cited deficiency 8/23/24 and 11/25/24</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>20725</p> <p>Based on observation and staff and resident interview, it was determined that the facility failed to implement enhanced barrier precautions for one of eight residents reviewed (Resident 2).</p> <p>Findings include:</p> <p>Review of the Centers for Medicare and Medicaid Services (CMS) memo entitled, Enhanced Barrier Precautions in Nursing Homes, dated March 20, 2024, revealed that nursing care facilities are to use enhanced barrier precautions (EBP, gown and glove use) for residents with chronic wounds or indwelling medical devices (i.e., indwelling urinary catheters) during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care.</p> <p>Interview with Resident 2 on March 18, 2025, at 9:13 AM, revealed that she had an indwelling urinary catheter (tube inserted into the bladder to drain urine). Observation of Resident 2's room door on the date and time of the interview revealed a sign to inform staff and visitors that enhanced barrier precautions were required to enter the room.</p> <p>Continued observation of Resident 2's room on March 18, 2025, at 9:14 AM revealed Employee 6 (nurse aide) emptied urine from Resident 2's indwelling urinary catheter collection bag into a graduated plastic container for disposal. Employee 6 wore gloves; however, did not don a gown during the device's care.</p> <p>Interview with Employee 6 on March 18, 2025, at 10:37 AM confirmed that she did not don a gown before providing care for Resident 2's indwelling urinary catheter; however, she had no extenuating circumstances that prevented her from doing so.</p> <p>The surveyor reviewed the above concern regarding the implementation of enhanced barrier precautions during an interview with the Nursing Home Administrator and Employee 1 (assistant director of nursing) on March 18, 2025, at 4:00 PM.</p> <p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control</p> <p>Previously cited deficiency 8/23/24</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		