

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 08/23/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>44738</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to accommodate resident needs regarding the accessibility of a call bell for one of 22 residents reviewed (Resident 74).</p> <p>Findings include:</p> <p>Clinical record review for Resident 74 revealed a diagnoses list that included unsteadiness on their feet, muscle weakness, abnormalities of gait and mobility, and dementia.</p> <p>A current care plan for Resident 74 revealed the resident is at risk for falls. An intervention listed on the care plan included to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Another intervention noted the resident needs a safe environment that included a working and reachable call light.</p> <p>Observation of Resident 74 on August 22, 2024, at 9:00 AM and 10:47 AM revealed the resident was in bed. The call bell was not within reach and located on the floor with the cord stuck under the wheel of the bed.</p> <p>Employee 9, nurse aide, was advised of the findings for Resident 74 on August 22, 2024, at 10:50 AM and proceeded to remove the call bell from underneath the wheel of the bed and placed it within reach of the resident.</p> <p>The above information for Resident 74 was reviewed with the Nursing Home Administrator and Director of Nursing on August 22, 2024, at 1:40 PM.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</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>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>20725</p> <p>Based on review of select facility policies and procedures, clinical record review, and staff and resident interview, it was determined that the facility failed to ensure a resident's right to choose activities consistent with her interests for one of 22 residents reviewed (Resident 100).</p> <p>Findings include:</p> <p>The facility policy entitled, Smoking Policy, last reviewed without changes on January 17, 2024, revealed that on admission, the Safe Smoking Assessment Form must be completed on any resident requesting to smoke. Upon completion of the assessment form, the individualized care plan will be completed to reflect the appropriate interventions for each resident. The designated smoking area for residents is outside the front entrance door near the provided receptacles.</p> <p>Interview with Resident 100 on August 21, 2024, at 9:40 AM revealed that she was told that she could not go outside, unless someone was with her, even though she believed that she had no issues with safety. Resident 100 stated that she smoked cigarettes before her admission to the facility and was not told that smoking would be prohibited until after her admission to the facility. Resident 100 stated that she only goes outside when staff will accompany her and that several men are smoking within a few feet of her while she is outside. Resident 100 denied that she signed any agreement to stop smoking upon her admission to the facility.</p> <p>Clinical record review for Resident 100 revealed nursing documentation dated July 26, 2024, at 1:09 PM that noted Resident 100 was at the nurses' desk inquiring when would, .she be cleared to go outside to smoke. Resident 100, Stated she was on the patch and held off of smoke while she was sick but feels she is well enough now to smoke and insistent that she will be smoking. The staff documented that they explained that they would inform and discuss the issue with the physician.</p> <p>Nursing documentation dated July 26, 2024, at 9:55 PM revealed that Resident 100 was, .mad and she says she feels like a prisoner here. Would not take pills or insulin this evening. She wants to go home.</p> <p>Behavioral progress note documentation dated July 29, 2024, at 2:06 PM revealed that Resident 100 was not happy at the facility, she wanted to speak to someone since she would be at the facility permanently, and that she wanted to start smoking again. Resident 100 was on nicotine patches and finished the cycle. Resident 100 indicated that she, .told herself when she was getting out (of the facility) she would restart (smoking).</p> <p>Behavioral progress note documentation dated August 20, 2024, at 6:19 PM revealed that Resident 100 refused to take medication and insulin; Resident is protesting and is mad because family will not allow her to smoke .</p> <p>Behavioral progress note documentation dated August 20, 2024, at 9:11 PM indicated that Resident 100 expressed, .being mad at her family for putting her here. Still would like to smoke.</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>Social services documentation dated August 21, 2024, at 9:44 AM indicated that Resident 100 asks about smoking or going home.</p> <p>The surveyor requested any evidence that the facility completed the Safe Smoking Assessment Form when Resident 100 requested to smoke during an interview with the Nursing Home Administrator, the Director of Nursing, and Employee 3 (registered nurse, infection control prevention coordinator), on August 21, 2024, at 2:30 PM.</p> <p>A Smoking/Electronic Cigarette Evaluation completed August 21, 2024, at 5:14 PM (after the surveyor's questioning), confirmed that Resident 100 requested to smoke, had a BIMS (Brief Interview for Mental Status, a scoring system to determine cognitive deficits; a score of 13 to 15 indicates no cognitive impairments) score of 15 and a SLUMS (St. Louis University Mental Status, an examination for detecting mild cognitive impairment; thought to be more sensitive than the mini-mental status examination) testing score of 27 out of 30 (normal). Staff offered, but Resident 100 declined, smoking cessation information and the nicotine patch. Resident 100 verbalized understanding of education and continued to request a smoking evaluation. The smoking evaluation was completed, Resident 100 was able to exit/enter the facility independently and was able to light and extinguish a cigarette safely. Resident 100 verbalized understanding of the facility smoking policy and materials are to be kept in the medication cart when not in use. Staff updated Resident 100's plan of care. Resident 100's responsible party was made aware and would provide smoking materials.</p> <p>The facility failed to facilitate Resident 100's self-determination of activities of her choice until after the surveyor's questioning.</p> <p>28 Pa. Code 201.29(a) Resident rights</p> <p>28 Pa. Code 209.3(a)(c) Smoking</p> <p>28 Pa. Code 211.10(a)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to establish clear and consistent resident wishes regarding advance directives for three of 33 residents reviewed (Residents 16, 101, and 102).</p> <p>Findings include:</p> <p>Clinical record review for Resident 102 revealed a POLST (Physician Orders for Life-Sustaining Treatment, a document for specific medical orders to be honored by health care workers during a medical crisis) in the resident's record dated [DATE], indicating it was the resident's wish to have CPR (cardiopulmonary resuscitation, a lifesaving procedure performed when the heart stops beating).</p> <p>Further review of Resident 102's clinical record revealed a physician's order dated [DATE], indicating Resident 102 was a DNR (do not resuscitate, no lifesaving procedures performed when the heart stops beating). Resident 102's physician orders for life sustaining treatment did not match the wishes indicated on Resident 102's POLST. There was no evidence of any discussion or updated advance directives to indicate Resident 102 had changed his wishes regarding life sustaining treatment since the [DATE], POLST was completed.</p> <p>The above discrepancy was reviewed with the Nursing Home Administrator and Director of Nursing on [DATE], at 2:00 PM.</p> <p>Resident 102's physician orders were updated on [DATE], after the above interview to indicate the Resident was now ordered CPR in the event the resident's heart would stop beating, to match the resident wishes as desired upon completion of the POLST form dated [DATE].</p> <p>Clinical record review for Resident 16 revealed that the facility admitted them on [DATE]. The responsible party signed a POLST on [DATE], indicating that their wishes were for Resident 16 to receive CPR (Cardiopulmonary Resuscitation). On [DATE], Resident 16's physician ordered staff to Do Not Resuscitate (DNR) Resident 16, which continued throughout the resident's stay until [DATE], after identified by the surveyor. There was no documentation that indicated Resident 16's responsible party changed or chose for them to become a DNR.</p> <p>Clinical record review for Resident 101 revealed that the facility admitted them on [DATE]. The resident signed a POLST form on [DATE], that indicated that their wishes were to be a DNR. On [DATE], Resident 101's physician ordered staff to provide CPR to Resident 101, which continued throughout the resident's stay until [DATE], after identified by the surveyor. There was no documentation indicating that Resident 101 changed or chose to receive CPR.</p> <p>The surveyor reviewed the above information during an interview on [DATE], at 2:12 PM with the Director of Nursing and the Nursing Home Administrator.</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725</p> <p>Based on resident observation and interview and staff interview, it was determined that the facility failed to ensure assessments accurately reflected a resident's status for one of 22 residents reviewed (Resident 23).</p> <p>Findings include:</p> <p>Interview with Resident 23 on August 21, 2024, at 10:30 AM revealed that she had not received the services of a professional dental provider, in a while. Resident 23 stated that she had broken and missing teeth. Resident 23 was reluctant to smile for the surveyor and stated that she was embarrassed of the condition of her teeth.</p> <p>Review of an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated January 17, 2024, revealed that staff assessed Resident 23 had no teeth (was edentulous). The assessment indicated that Resident 23 had no obvious or likely cavities or broken natural teeth. The assessment triggered staff to develop a plan of care due to Resident 23's edentulous status.</p> <p>There was no evidence in Resident 23's medical record that staff developed a plan of care regarding Resident 23's dental status.</p> <p>A significant change MDS dated [DATE], assessed that Resident 23 had natural teeth (was not edentulous) but that she had no obvious or likely cavities or broken natural teeth.</p> <p>Interview with Employee 14 (licensed practical nurse assessment coordinator) and Employee 4 (registered nurse assessment coordinator) on August 23, 2024, at 9:48 AM confirmed that both the admission and significant change MDS assessments for Resident 23 were incorrect regarding her dentition. The interview confirmed that Resident 23 was missing teeth and had natural teeth that were likely broken and/or had cavities. The interview confirmed that the facility could not provide a plan of care that addressed Resident 14's dental condition.</p> <p>28 Pa. Code 211.5(f)(i)-(xi) Medical records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>44738</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered medications for two of 22 residents reviewed (Residents 51 and 72).</p> <p>Findings include:</p> <p>Review of the current physician orders for Resident 51 dated May 21, 2024, instructed staff to monitor for side effects (that included constipation) of anti-anxiety medications. The other order instructed staff to monitor for side effects (that included constipation) of anti-depressant medications.</p> <p>Clinical record review for Resident 51 revealed a current care plan that revealed the resident has an alteration in gastrointestinal status. An intervention included to administer medications as ordered and observe for/document side effects and effectiveness.</p> <p>Clinical record review for Resident 51 revealed the following physician orders to promote bowel movements:</p> <p>Dulcolax Oral Tablet (a laxative medication used to relieve constipation) delayed release 5 milligrams (mg) give one tablet by mouth as needed for constipation every three days on evening shift.</p> <p>Biscolax Suppository (Bisacodyl, a medication used to relieve constipation) 10 mg; insert one suppository rectally as needed for constipation every fourth day on evening shift as needed for constipation and oral Dulcolax is ineffective.</p> <p>Soap suds enema (a method of administering a fluid and a mild soap into the rectum to help relieve constipation) rectally every five days on 11 - 7 shift as needed if the suppository is ineffective.</p> <p>Review of bowel elimination records for Resident 51 revealed that staff documented no bowel movements for July 30, 31, August 1-5, 2024.</p> <p>A review of the Medication Administration Record (MAR) for Resident 51 revealed staff attempted to administer a Biscolax Suppository on August 5, 2024, at 5:41 PM, which was documented as refused by the resident.</p> <p>There was no indication that staff offered (as per the physician orders and bowel management protocol) or Resident 51 refused, any other PRN medications.</p> <p>Clinical record review for Resident 72 revealed a current hospice care plan that instructed staff to notify the registered nurse if no bowel movement.</p> <p>Clinical record review for Resident 72 revealed the following physician orders to promote bowel movements:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Bisacodyl tablet delayed release 5 mg give one tablet by mouth as needed for no bowel movement every three days, give on 3 - 11 shift.</p> <p>Biscolax suppository 10 mg; insert one suppository rectally as needed for constipation every fourth day as needed on evening shift for constipation if Bisacodyl tablet is ineffective.</p> <p>Soap suds enema rectally every five days give on 11 - 7 shift as needed for constipation if the suppository is ineffective.</p> <p>Review of bowel elimination records for Resident 72 revealed that staff documented no bowel movements for August 5, 6, 7, 8, and 9, 2024.</p> <p>A review of the Medication Administration Record (MAR) for Resident 72 revealed that staff administered a Bisacodyl tablet delayed release on day three (August 7, 2024, at 9:43 PM) of no bowel movement as per the physician orders. However, there was no indication that staff offered (as per physician orders), or Resident 72 refused any additional PRN bowel medications on day four and five with no bowel movement documented.</p> <p>The Nursing Home Administrator and Director of Nursing were informed of the findings for Residents 51 and 72 on August 23, 2024, at 1:45 PM.</p> <p>483.25 Quality of Care</p> <p>Previously cited 9/22/2023</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>29512</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide services to maintain a resident's range of motion for three of four residents reviewed (Residents 16, 30, and 50).</p> <p>Findings include:</p> <p>Clinical record review for Resident 16 revealed a current care plan for staff to provide a restorative nursing program (RNP) to maintain the resident's range of motion (ROM, movement of the body to maintain a resident's ability) to ambulate for 20 feet with a rolling walker with assist of one and use of a gait belt.</p> <p>Review of task documentation for Resident 16 revealed that staff did not document completion or documented NA (Not Applicable) of the restorative task on the following dates:</p> <p>Day Shift:</p> <p>June 15, 25; July 1, 9; August 1, 2, 3, 4, and 6, 2024</p> <p>Evening Shift:</p> <p>June 13, 22; July 15, 20; August 18, 2024</p> <p>Staff documented several refusals by Resident 16 throughout June, July, and August 2024. There was no facility documentation that identified this CLOF (current level of function).</p> <p>Clinical record review for Resident 30 revealed a therapy evaluation dated March 12, 2024, for staff to provide a RNP to ambulate up to 40 feet daily with a platform walker with assist of one, use of a gait belt, and a wheelchair to follow.</p> <p>Review of task documentation for Resident 30 revealed that staff did not implement the therapy recommended RNP for ambulation until July 11, 2024, four months later.</p> <p>Further review of task documentation after July 11, 2024, for Resident 30 revealed that staff implemented the RNP ambulation for both day and evening shift staff to complete. Staff did not document completion or documented NA of the restorative task on the following dates:</p> <p>Day Shift:</p> <p>July 16, 23, and 29; August 1, 3, and 4, 2024</p> <p>Evening Shift:</p> <p>July 15 and 20; August 17 and 18, 2024</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Staff documented frequent refusals by Resident 30 throughout July and August 2024, to ambulate, especially on evening shifts. There was no facility documentation which identified this CLOF.</p> <p>Clinical record review for Resident 50 revealed a current care plan and task for staff to provide a RNP which included:</p> <p>Walk with supervision with a rolling walker, 60-100 feet with a wheelchair to follow for 15 minutes twice daily.</p> <p>Transfer with supervision and verbal cues for hand placement on the rolling walker. Practice 15 minutes daily.</p> <p>Review of task documentation for Resident 50 revealed that staff implemented the RNP ambulation and transfer for both day and evening shift staff to complete. Staff did not document completion or documented NA of the restorative task on the following dates:</p> <p>Walk with supervision with a rolling walker, 60-100 feet with a wheelchair to follow for 15 minutes twice daily.</p> <p>Day Shift:</p> <p>June 26 and 27; July 9, 10, 15, and 29; August 18, 2024</p> <p>Evening Shift:</p> <p>June 13 and 22; July 5, 7, 8, 13, 14, 16, and 18; August 7, 2024</p> <p>Transfer with supervision and verbal cues for hand placement on the rolling walker. Practice 15 minutes daily.</p> <p>Day Shift:</p> <p>July 9, 10, and 15; August 18, 2024</p> <p>Evening Shift:</p> <p>June 15 and 22; July 5, 7, 8, 13, 14, 16, and 18; August 7, 2024</p> <p>Staff documented frequent refusals by Resident 50 throughout July and August 2024, to ambulate, especially on evening shifts. There was no facility documentation that identified this CLOF.</p> <p>The surveyor reviewed the above information on August 22, 2024, at 2:10 PM with the Director of Nursing.</p> <p>483.25(c)(1)-(3) Increase/prevent Decrease In Rom/mobility</p> <p>Previously cited 9/22/23</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>29512</p> <p>Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to implement interventions to prevent falls and injuries for two of five residents reviewed for falls (Resident 16 and 103).</p> <p>Findings include:</p> <p>Clinical record review for Resident 16 revealed that the facility requested a therapy screen as a result of a fall on May 22, 2024. Physical and occupational therapy staff screened Resident 16 on May 23, 2024. Occupational therapy (OT) staff recommended patient in heavily supervised areas when OOB (out of bed) to prevent falls. There was no documentation available that indicated the facility implemented OT's recommendation dated May 23, 2024.</p> <p>Review of facility and nursing documentation revealed that Resident 16 fell and sustained injuries on the following dates:</p> <p>On July 14, 2024, at 2:44 PM Resident 16 was found in her room on her knees on the right side of the bed with her elbows resting on her wheelchair. Resident 16 was last observed by staff in her wheelchair. Resident 16 sustained a 1.0-centimeter (cm) by 3.0 cm laceration under her left fifth (pinkie) toe and a 0.1 cm x 2.0 cm laceration under her left nostril. The facility sent Resident 16 to the emergency room (ER) for evaluation.</p> <p>On August 16, 2024, at 1:42 PM Resident 16 was found in her room sitting upright on her buttocks with her head resting on the overbed tray behind her and the wheelchair in front of her. Staff indicated that they had picked up her meal tray and toileted her at 12:35 PM. Resident 16 sustained a 4 cm by 0.2 cm head laceration. The facility sent Resident 16 to the ER for evaluation. She returned with her head stapled to close the laceration.</p> <p>This surveyor reviewed this information during an interview with the Director of Nursing on August 23, 2024, at 11:00 AM</p> <p>Clinical record review for Resident 103 revealed nursing documentation dated April 30, 2023, at 11:30 PM that the nurse aide called the nursing supervisor to Resident 103's room where Resident 103 was found on a wet floor. The documentation indicated that a bed alarm was in place, turned on, but did not sound. The documentation indicated that staff changed the bed alarm pad.</p> <p>A review of nurse aide task documentation (electronic documentation completed by nurse aides) and medication and treatment administration records dated April 2024, did not include evidence that a bed alarm was an intervention in Resident 103's plan of care. No staff initialed the completion of a task related to ensuring the correct application of the device.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nursing documentation dated May 1, 2024, at 6:32 PM revealed that the nurse aide called the nursing supervisor to Resident 103's room where Resident 103 was found on the bathroom floor. A chair alarm did not sound due to the finding that there were no batteries in the alarm box. The documentation indicated that staff replaced the batteries in the alarm box and the bed/chair alarm was functioning.</p> <p>Review of the facility's investigation of Resident 103's fall on May 1, 2024, at 4:45 PM reiterated that the chair alarm did not sound due to the absence of batteries in the alarm box; however, no investigation determined when staff last verified the correct placement of the alarm. The investigation did not determine what happened to the batteries that should have been in the box (to ensure appropriate disposal of the batteries).</p> <p>A review of nurse aide task documentation and medication and treatment administration records dated May 2024, did not include evidence that a bed alarm was an intervention in Resident 103's plan of care on May 1, 2024. No staff initialed the completion of a task related to ensuring the correct application of the device.</p> <p>A physician's order revision dated May 2, 2024, discontinued a physician's order dated March 17, 2024, that instructed staff to apply a mat alarm to Resident 103's bed and wheelchair.</p> <p>Nursing documentation dated May 28, 2024, at 10:39 AM indicated that staff noted Resident 103 sitting on the floor.</p> <p>Review of the facility's investigation of Resident 103's fall on May 28, 2024, revealed that predisposing situation factors did not indicate the presence of a bed or chair alarm; however, a nurse aide staff witness statement indicated that an alarm activated.</p> <p>The physician orders, nurse aide task documentation, and medication and treatment administration records dated May 2024, did not include evidence that a bed or wheelchair alarm was an intervention in Resident 103's plan of care as of May 28, 2024. No staff initialed the completion of a task related to ensuring the correct application of the device.</p> <p>Nursing documentation dated July 3, 2024, at 9:03 AM revealed that an alarm activated at 8:40 AM and staff observed Resident 103 sitting on the floor, with his legs extended in front of the wheelchair.</p> <p>Review of the facility's investigation of Resident 103's fall on July 3, 2024, included a nurse aide witness statement that attested that an alarm activated.</p> <p>The physician orders, nurse aide task documentation, and medication and treatment administration records dated July 2024 did not include evidence that a bed or wheelchair alarm was an intervention in Resident 103's plan of care as of July 3, 2024. No staff initialed the completion of a task related to ensuring the correct application of the device.</p> <p>Nursing documentation dated July 9, 2024, at 8:27 PM revealed that staff found Resident 103 walking in the hallway, . and (he) fell on the floor on his left side. This was a witnessed (fall) via the LPN (licensed practical nurse) on the unit. The documentation indicated that Resident 103 complained of pain when his left leg moved or was palpated. The physician ordered an x-ray of the left leg.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nursing documentation dated July 10, 2024, at 9:48 AM revealed that the x-ray report was positive for a femur (large leg bone) fracture near his hip. Resident 103 left the facility for evaluation at the hospital emergency room .</p> <p>Review of the facility's investigation of Resident 103's fall on July 9, 2024, again included witness statements from two nurse aides that an alarm was correctly placed and activated; however, physician orders, nurse aide task documentation, and medication and treatment administration records dated July 2024, did not include evidence that a bed or wheelchair alarm was an intervention in Resident 103's plan of care as of July 9, 2024. No staff initialed the completion of a task related to ensuring the correct application of the device.</p> <p>A physician's order dated July 14, 2024, (upon Resident 103's readmission to the facility) instructed staff to utilize a pressure alarm to Resident 103's bed and chair. Staff were instructed to check placement and functioning every shift.</p> <p>Review of nurse aide task documentation dated July 2024, revealed that nurse aide staff began documenting the proper placement of a bed alarm and a chair alarm on July 14, 2024.</p> <p>Observation of Resident 103 on August 21, 2024, at 9:06 AM revealed he was seated in a low wheelchair leaning forward onto his bedside table. A loose cord dangled from the back of his wheelchair.</p> <p>Interview with Employee 8 (LPN) on August 21, 2024, at 9:17 AM revealed the loose cord dangling from Resident 103's wheelchair was for his chair alarm. Staff failed to insert the cord into the alarm box when Resident 103 was transferred out of bed to his wheelchair. Employee 8 activated Resident 103's chair alarm at that time.</p> <p>Interview with Employee 13 (nurse aide) on August 21, 2024, at 9:22 AM confirmed that she was Resident 103's assigned nurse aide and that she did not attach Resident 103's wheelchair alarm before the surveyor's observation.</p> <p>The surveyor reviewed the above findings regarding Resident 103's falls during an interview with the Director of Nursing and Employee 3 (registered nurse, infection control prevention coordinator) on August 23, 2024, at 1:15 PM.</p> <p>28 Pa. Code 201.18(e)(1) Management</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>38839</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to provide respiratory care consistent with professional standards of practice with the administration of supplemental oxygen for two of four residents reviewed for oxygen use (Residents 78 and 35).</p> <p>Findings include:</p> <p>An observation of Resident 78 on August 20, 2024, at 12:55 PM revealed the resident in bed with oxygen being administered via a nasal cannula (tubing piece inserted into the nostrils to administer supplemental oxygen). There was no evidence of any date on the resident oxygen tubing, or bag that hung on the side of the resident's oxygen concentrator where the tubing was attached to indicate when the tubing was placed there. There was no evidence in Resident 78's clinical record to indicate when the resident's oxygen tubing and nasal cannula was changed.</p> <p>An observation of Resident 35 on August 21, 2024, at 11:40 AM revealed the resident in bed with oxygen being administered via nasal cannula. There was no date on the oxygen tubing or oxygen concentrator to indicate when the tubing was placed there or last changed. A CPAP machine (a continuous positive airway pressure machine used to keep airways open while you sleep) was also observed on Resident 35's bedside stand with an unbagged mask lying on top of stacks of papers, and a pile of snack food bags.</p> <p>The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on August 21, 2024, at 2:00 PM.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>44738</p> <p>Based on review of select facility policies and procedures, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to assess the entrapment risk of assist bar (side rail) use for eight of nine residents reviewed for accident concerns (Residents 23, 24, 26, 30, 37, 50, 51, and 78)</p> <p>Findings include:</p> <p>The facility policy titled, Enabler Bar Protocol, last reviewed without changes on January 17, 2024, revealed that it is the purpose of the facility to assist the resident in attaining and maintaining his or her highest practicable level of physical and psychosocial well-being. Some of the procedures regarding the use of enabler bars included the following: The Bed System Measurement Device Test, form will be completed upon admission or when initiated, and with any change in bed and/or mattress. If any zones do not pass the above test, the bed and/or mattress will be taken out of use immediately. The facility will complete the Bed System Measurement Device Test form upon admission, when initiated, and with any change in bed and/or mattress change.</p> <p>Clinical record review for Resident 24 revealed an active physician's order dated December 7, 2023, for the use of halo assist rings for bed mobility.</p> <p>Further review of the physician orders for Resident 24 revealed an order dated September 13, 2023, for an alternating air mattress.</p> <p>A Bed System Measurement Device Test Results Worksheet, dated August 27, 2023, indicated that the resident was utilizing a MedHealth Care bed with an air mattress. The entrapment zone measurement area to indicate if each zone (zone one through four) passed or failed the appropriate measurements had a large X drawn over it with no noted documentation of any zone passing or failing.</p> <p>Observation of Resident 24 on August 21, 2024, at 10:05 AM revealed the resident was in bed with an air mattress and bilateral halo bars were attached to the bed. A concurrent interview with the resident indicated the halo bars were used to assist with bed mobility.</p> <p>An interview with Employee 6, Maintenance Director, on August 23, 2024, at 10:20 AM revealed that beds with assistive devices that have an air mattress are not assessed for entrapment risks. Employee 6 was unable to provide documented evidence (such as evidence from the manufacturer) to indicate that the entrapment zone risk assessments were not necessary.</p> <p>Observation of Resident 51 on August 21, 2024, at 9:23 AM revealed the resident was in a larger bed with bilateral enabler bars. A concurrent interview with the resident revealed the bars are used to assist with repositioning and pulling herself up in bed.</p> <p>A current care plan for Resident 51 indicated an activities of daily living (ADL) self-care performance deficit. An intervention included utilizing a bariatric bed to facilitate bed mobility.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of facility documentation (no date) titled BIG BOYZ Assist Bar, the type of enabler bar the facility indicated was on Resident 51's bed, revealed the bars have been .designed for those requiring help with standing, shifting or transferring in out of bed. The documentation further noted that the bars, .can be utilized in multiple positions without the fear of entrapment.</p> <p>The facility provided no further evidence to indicate that a risk assessment was completed to ensure that Resident 51's bed and the associated enabler bars were free from entrapment risks.</p> <p>An interview with Employee 6 on August 23, 2024, at 10:20 AM revealed that the bars are a permanent part of the bed and come attached to the bariatric bed. Employee 6 confirmed that entrapment zone measurements were not completed on the bed.</p> <p>The Nursing Home Administrator and Director of Nursing were informed of the findings for Residents 24 and 51 on August 23, 2024, at 1:45 PM.</p> <p>An observation of resident 78 on August 20, 2024, at 12:59 PM revealed the resident was in bed. Metal assist bars were observed on both sides of the resident's bed. An air mattress was observed on the bed.</p> <p>There was no evidence facility staff had completed an assessment of the entrapment zones of the assist bars and the resident's mattress to assure there was no risk of entrapment.</p> <p>In an interview with Employee 6 on August 23, 2024, at 10:23 AM Employee 6 indicated the entrapment zones are not measured on the bariatric bed due to the assist bars coming installed from the manufacturer for the bariatric bed.</p> <p>The manufacturer information for the assist bars indicated the assist bar can be utilized in multiple positions without the fear of entrapment, although no evidence was provided to indicate the entrapment zones should not be tested , or if the risk changes due to the type of mattress on the bed.</p> <p>The above information for Resident 78 was reviewed with the Director of Nursing on August 23, 2024, at 11:29 AM.</p> <p>Clinical record review for Resident 37 revealed a current physician order for her to utilize bilateral halo (circular) safety rings. A Bed System Measurement Test Results Worksheet (BSMTRW) dated September 21, 2020, revealed that the facility measured, assessed, and passed the halo enabler bars while Resident 37 was in a specific bed and room. Since the BSMTRW was completed Resident 37 had moved to several different rooms. There was no documentation that indicated another BSMTRW was completed or that the same bed and halo system was moved with Resident 37 with each room move.</p> <p>Observation of Resident 37 on August 20, 2024, at 9:34 AM and August 21, 2024, at 9:18 AM revealed that they were in bed and there were bilateral halo enabler bars observed on the bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review for Resident 50 revealed a current physician's order for her to utilize bilateral halo safety rings. A BSMTRW dated March 4, 2020, revealed that the facility measured, assessed, and passed the enabler bars while Resident 50 was in a specific room and bed. Since the BSMTRW was completed Resident 50 had moved to different rooms. There was no documentation that indicated another BSMTRW was completed or that the same bed and halo system was moved with Resident 50 with each room move.</p> <p>Observation of Resident 50 on August 21, 2024, at 9:16 AM revealed that they were in bed and there were bilateral halo enabler bars observed on the bed.</p> <p>Observation of Resident 30 on August 20, 2024, at 9:33 AM, August 21, 2024, at 9:13 AM, and on August 23, 2024, at 10:00 AM and 10:19 AM, revealed that they were in a bariatric bed and there were bilateral square waffle-like one-quarter side rails on the bed. Concurrent interview with Employee 2, licensed practical nurse, on August 23, 2024, at 10:19 AM confirmed the observation, and Employee 2 informed maintenance to complete a BSMTRW. She indicated that she was informed that any bariatric bed in the facility that included a side rail did not need to be evaluated.</p> <p>Clinical record review for Resident 30 revealed no documentation that the bilateral square waffle-like one-quarter side rails were assessed for the risk of entrapment.</p> <p>Interview with the Employee 6, maintenance director, on August 23, 2024, at 10:23 AM confirmed that he was informed that bariatric beds that included a side rail within the facility did not need a BSMTRW as the bariatric bed Big Boyz side rail was a factory installed complete package. Employee 6 confirmed that Resident 30 had a bariatric bed but did not have the factory installed Big Boyz side rail implemented. Employee 6 could not provide documentation that the facility completed a BSMTRW on Resident 30's bariatric bed and square waffle-like one-quarter side rails to ensure that the bariatric bed was free of entrapment zones.</p> <p>The surveyor reviewed the above information during an interview with the Nursing Home Director and the Director of Nursing on August 21, 2024, at 2:00 PM, and the Director of Nursing on August 23, 2024, at 10:05 AM revealed the facility did not evaluate bariatric beds with a side rail system as the bed is delivered with side rails as a package. The bed system was factory installed and indicated no entrapment risks. The DON confirmed that the facility followed their policy and will not reassess the bed and rail system applied to a resident's bed; however, could not provide documentation that the resident's bed and rail system assessed in 2020 was the current bed and rail system being utilized by the resident currently, especially with room moves that were required if a resident tested positive for COVID-19 during the COVID-19 outbreak.</p> <p>Observation of Resident 23's room on August 21, 2024, at 10:42 AM revealed that the head of her bed was equipped with Halo circular devices bilaterally.</p> <p>Clinical record review for Resident 23 revealed a BSMTRW dated January 30, 2024, that indicated Resident 23 utilized an air mattress. There was a large, handwritten, X, over the zone assessments that indicated that staff did not assess the zones for potential entrapment risks.</p> <p>Observation of Resident 26's room on August 21, 2024, at 9:57 AM revealed that the head of her bed was equipped with Halo circular devices bilaterally.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Comprehensive Enabler Bar(s) Assessment, dated September 19, 2023, indicated that Resident 26 required bilateral Halos for turning in bed. The document indicated that no Bed System Measurement Device Test, was completed with the explanation of, air mattress.</p> <p>An attached BSMTRW dated September 19, 2023, indicated Resident 26 utilized an air mattress. There was a large, handwritten, X, over the zone assessments that indicated that staff did not assess the zones for potential entrapment risks.</p> <p>The surveyor confirmed the above findings during an interview with the Director of Nursing and the Nursing Home Administrator on August 22, 2024, at 1:30 PM.</p> <p>Interview with Employee 2 (licensed practical nurse) on August 23, 2024, at 10:06 AM indicated that there is no resource material available from Halo (the manufacturer of Resident 23's assist devices) or the manufacturer of Resident 23's air mattress that indicated the devices have been evaluated for safe use when used together. Employee 2 stated that she does not complete the entrapment zone measurement assessments and maintenance staff document their assessments separately.</p> <p>Interview with Employee 6 (maintenance director) on August 23, 2024, at 10:20 AM revealed that he does not assess any bed system that includes an air mattress for entrapment zone risks. Employee 6 could not provide a resource that indicated that the use of an air mattress eliminated the risk for entrapment from an assistive device. Employee 6 stated that he was told verbally during part of his training. Employee 6 confirmed that he had no documentation from Halo, the air mattress manufacturer, or the FDA that indicated the Halo, and the air mattress devices could be utilized together safely.</p> <p>Information from the air mattress manufacturer stipulated that it is the responsibility of the facility to be in compliance with laws and to make the determination on the use of siderails on an individual patient basis.</p> <p>Information from Halo Safety Ring (https://www.halomobilitysolutions.com/products/halo-safety-ring) stipulated that the Halo Safety Ring is not intended to prevent bed entrapment or a user from inadvertently rolling out of bed.</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 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>44738</p> <p>Based on employee personnel review and staff interview, it was determined that the facility failed to complete a performance evaluation of each nurse aide at least once every 12 months for three of three nurse aides reviewed (Employees 10, 11, and 12).</p> <p>Findings include:</p> <p>The facility noted the following hire dates for three employees reviewed for performance evaluations:</p> <p>Employee 10's hire date of February 15, 2007</p> <p>Employee 11's hire date of May 23, 2023</p> <p>Employee 12's hire date of October 21, 2020.</p> <p>A request to review the annual performance evaluations revealed no documented evidence that the facility is completing the evaluations at least once every 12 months.</p> <p>Interview with the Nursing Home Administrator on August 23, 2024, at 12:40 PM confirmed that performance evaluations were not completed on the three employees.</p> <p>28 Pa. Code 201.19 (2) Personnel policies and procedures</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>38839</p> <p>Based on staff interview and clinical record review, it was determined that the facility failed to ensure that a medication was available in a timely manner for 3 of 3 residents reviewed for medication availability concerns (Residents 57, 24, and 50).</p> <p>Findings include:</p> <p>Clinical record review for Resident 57 revealed a physician's order dated March 14, 2024, indicating the resident was to receive phenobarbital tablets (a medication used to prevent and control seizures) every 12 hours for a diagnosis of unspecified convulsions.</p> <p>A review of Resident 57's August 2024, medication administration record (MAR) revealed Resident 57 did not receive the morning or evening dose of the phenobarbital on August 9, 2024.</p> <p>Further clinical record review revealed a nursing medication administration note dated August 9, 2024, at 8:11 AM noting that the resident's phenobarbital was not administered due to it being unavailable and awaiting delivery from the pharmacy. An additional nursing medication administration note dated August 9, 2024, at 8:59 PM noted the resident's evening dose of phenobarbital was not administered indicating that they were awaiting delivery. Resident 57 did not receive the phenobarbital until the next dose was due the morning of August 10, 2024.</p> <p>A review of a document provided by facility staff indicated a refill of the resident's phenobarbital was ordered from the pharmacy for the resident on August 7, 2024.</p> <p>In an interview with the Director of Nursing on August 23, 2024, at 9:30 AM she indicated she was unsure the reason the phenobarbital was not delivered to the facility in time to prevent Resident 57 from missing any doses of the medication.</p> <p>Clinical record review for Resident 24 revealed a physician's order dated September 26, 2023, that indicated the resident was to receive oxycodone HCl (a medication used to treat moderate to severe pain) 10 milligrams (mg) every eight hours related to chronic pain.</p> <p>Nursing documentation for Resident 24 dated July 15, 2024, at 11:09 PM revealed that the 10:00 PM dose of oxycodone was not given and did not arrive on the 10:45 PM pharmacy delivery. The documentation noted a new signed script did not come through and remains outstanding. The medication will not be filled until the script is received.</p> <p>A medication administration note for Resident 24 dated August 15, 2024, at 10:27 PM revealed staff were awaiting delivery of the oxycodone. The dose was not checked as administered as per physician order on the MAR.</p> <p>A medication administration note for Resident 24 dated August 16, 2024, at 5:55 AM revealed staff were awaiting pharmacy delivery of the oxycodone. The dose was not checked as administered as per physician order on the MAR.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A medication administration note for Resident 24 dated August 19, 2024, at 1:17 PM revealed that the oxycodone was not available from pharmacy. The dose was not checked as administered as per physician order on the MAR.</p> <p>A medication administration note for Resident 24 dated August 19, 2024, at 9:21 PM revealed staff were, Awaiting for script. Dose not available. The dose was not checked as administered as per physician order on the MAR.</p> <p>The facility failed to obtain and maintain timely and appropriate pharmaceutical services that supported Resident 24's healthcare needs, goals, and quality of life that are consistent with current standards of practice.</p> <p>The Nursing Home Administrator and Director of Nursing were informed of the above information for Resident 24 on August 23, 2024, at 1:45 PM.</p> <p>Clinical record review for Resident 50 revealed current physician orders for the following:</p> <p>Physician signature authorizes a 30-day supply with five additional refills per prescription.</p> <p>Oxycodone Tablet 5 milligram (mg) one-half tablet (2.5 mg) by mouth (PO) at bedtime (HS) for bilateral osteoarthritis of the knee.</p> <p>Review of Resident 50's June and July 2024's MAR (medication administration record, a form to document medication administration) and Resident 50's Oxycodone narcotic controlled substance record revealed that the facility's contracted pharmacy did not provide her Oxycodone medication on June 29 and 30, 2024, and July 1, 2024.</p> <p>Review of Resident 50's nursing documentation and June and July 2024's MAR revealed the following:</p> <p>On June 29, 2024, at 9:28 PM, and June 30, 2024, at 8:19 PM staff documented that they could not administer Resident 50's Oxycodone because they were waiting for pharmacy delivery.</p> <p>On July 1, 2024, at 10:53 PM staff documented that they could not administer Resident 50's Oxycodone because it was on order.</p> <p>On July 2, 2024, at 11:17 PM staff documented that they administered Resident 50's Oxycodone medication at that time due to the medications late arrival from the pharmacy.</p> <p>There was no documentation that the pharmacy ensured that Resident 50 received her routine Oxycodone medication between June 29, 2024, and July 1, 2024.</p> <p>This surveyor reviewed the above information during an interview with the Director of Nursing on August 23, 2024, at 10:55 AM.</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy services</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>29512</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to ensure a medication error rate below five percent (Resident 91).</p> <p>Findings include:</p> <p>The facility's medication error rate was 6.06 percent based on 33 medication opportunities with two medication errors.</p> <p>Observation of a medication administration pass on August 20, 2024, at 10:02 AM revealed that Employee 1, licensed practical nurse, administered Dulera 200 mcg (micrograms) - 5 milligrams (mg) per actuation (puff), one puff orally to Resident 91. Employee 1 did not instruct and ensure Resident 91 rinsed her mouth with water after the administration.</p> <p>Further medication administration observation with Employee 1 revealed that she administered Spiriva Respimat Inhalation Aerosol solution 2.5 mcg per actuation (puff), two puffs orally to Resident 91. Employee 1 did not instruct and ensure Resident 91 rinsed her mouth with water after the administration.</p> <p>Clinical record review for Resident 91 revealed the following current physician orders:</p> <p>Dulera 200 mcg - 5 mg per actuation, two puffs orally every morning and at bedtime for chronic obstructive pulmonary disease. Rinse mouth after each use.</p> <p>Spiriva Respimat Inhalation Aerosol Solution 2.5 mcg per actuation, two puffs orally one time a day for chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. Rinse mouth with water after each use.</p> <p>Interview with Employee 1 on August 20, 2024, at 10:05 AM confirmed that she only administered one puff of Dulera, not two as ordered, to Resident 91 and failed to instruct and ensure that Resident 91 rinsed her mouth after both the Dulera and Spiriva medication administrations.</p> <p>The surveyor reviewed the above information during an interview on August 22, 2024, at 2:06 PM with the Director of Nursing and the Nursing Home Administrator.</p> <p>483.45(f)(1) Free of Medication Error Rts 5 Prcnt Or More</p> <p>Previously cited 9/22/23</p> <p>28 Pa. Code 211.9 (a)(1)(k) Pharmacy services</p> <p>28 Pa. Code 211.10(a)(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0848</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide a neutral and fair arbitration process and agree to arbitrator and venue.</p> <p>20725</p> <p>Based on review of the facility's arbitration agreements and staff interview, it was determined that the facility's arbitration agreements failed to ensure a neutral and fair arbitration process by ensuring the selection of a neutral arbitrator for three of three residents reviewed with a signed arbitration agreement (Residents 39, 52, and 103).</p> <p>Findings include:</p> <p>Review of a Mandatory Binding Arbitration Agreement (an agreement that the resident/resident's responsible party and the facility will resolve legal disputes through binding arbitration, waiving their right to a trial) signed by Resident 39's responsible party on March 28, 2023, revealed that the document stipulated that, All Arbitrations shall be administered by (name of arbitrator services company, which the facility utilized). The document also stipulated that if, . (name of arbitrator services company, which the facility utilized), is unable or unwilling to handle the Arbitration, the parties will work in good faith to agree on an alternative neutral arbitration service, and if the parties cannot reach an agreement within thirty (30) days, the Facility will select a neutral arbitrator to resolve the arbitration .</p> <p>The agreement afforded the facility the selection of the arbitrator (third-party decision-maker contracted to resolve a dispute) initially and/or if the parties cannot reach an agreement on a neutral arbitration service within 30 days.</p> <p>Review of an Arbitration Agreement signed by Resident 52's responsible party on June 27, 2023, revealed that the document stipulated that, By signing this Arbitration Agreement, the parties hereby agree that if the parties cannot agree on a neutral arbitrator after thirty days, then (name of arbitrator services company, which the facility utilized), will serve as neutral arbitrator in accordance with the (name of arbitrator services company, which the facility utilized) Rules of Procedure.</p> <p>The document afforded the facility the selection of the arbitrator if the parties (Resident 52/Resident 52's responsible party and the facility) cannot reach an agreement on a neutral arbitration service within 30 days.</p> <p>Review of an Arbitration Agreement signed by Resident 103's responsible party on March 12, 2024, revealed that the document stipulated the same verbiage as Resident 52's agreement; that if the parties cannot agree on a neutral arbitrator after 30 days, then (name of arbitrator services company, which the facility utilized), will serve as neutral arbitrator in accordance with the (name of arbitrator services company, which the facility utilized) Rules of Procedure.</p> <p>The surveyor reviewed the above concerns regarding arbitration agreements for Residents 39, 52, and 103 during an interview with the Nursing Home Administrator on August 21, 2024, at 11:50 AM.</p> <p>(continued on next page)</p>		

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<p>F 0848</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Employee 7 (admissions director) on August 23, 2024, at 11:08 AM confirmed that the agreements provided stipulate that, at some point, the facility could select the arbitrator; either initially and/or if the parties cannot reach an agreement on a neutral arbitration service within 30 days. Employee 7 stated that she believed the company is revising the agreement; however, the residents reviewed have not signed an updated agreement.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(2) Management.</p> <p>28 Pa. Code 201.29(a)(j) Resident rights</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725</p> <p>Based on review of select facility policies and procedures, observation, clinical record review, and staff and resident interview, it was determined that the facility failed to ensure the implementation of isolation precautions for two of three residents reviewed for transmission based precautions (Residents 28 and 30); implement enhanced barrier precautions for two of three residents reviewed for enhanced barrier precautions (Residents 103 and 107); enforce restriction-to-work guidelines for one of two staff that tested positive for COVID-19 (Employee 5); implement measures to monitor and prevent the growth of opportunistic pathogens within the facility's water system; and ensure an environment free from the potential spread of infection on one of four resident hallways (Maple hall, Resident 29).</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>Clinical record review for Resident 103 revealed weekly pressure injury evaluation documentation dated August 20, 2024, that indicated Resident 103 had a pressure ulcer on his right heel.</p> <p>Observation of Resident 103's room on August 21, 2024, at 9:22 AM revealed an EBP sign before entering his room and a yellow PPE (personal protective equipment, gowns, and gloves) divider on his door. Interview with Employee 13 (nurse aide) on the date and time of the observation indicated that the EBP in place for Resident 103 were necessary because he had a leg wound.</p> <p>Clinical record review for Resident 103 revealed a new physician's order dated August 21, 2024, for staff to implement EBP related to a pressure ulcer of his right heel.</p> <p>Observation of Resident 103's wound treatment on August 22, 2024, at 9:27 AM revealed Employee 2 (licensed practical nurse) and Employee 4 (registered nurse assessment coordinator) performed hand hygiene and donned gloves to begin the treatment. Neither Employee 2 nor Employee 4 donned an isolation gown. Employees 2 and 4 completed all the steps of removing Resident 103's soiled dressings, wound cleansing, and new dressing application without wearing an isolation gown.</p> <p>Interview with Resident 107 on August 21, 2024, at 10:13 AM revealed that he had open wounds to his right lower extremity, and staff complete daily wound treatments. Resident 107 stated that staff wear gloves; however, staff do not don a gown when performing his wound care. Observation of Resident 107's room on the date and time of the observation revealed no evidence of the implementation of enhanced barrier precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of Resident 107's wound treatments on August 22, 2024, at 9:41 AM revealed Employee 2 and Employee 4 donned gloves to begin Resident 107's wound care. Neither employee donned an isolation gown. Employees 2 and 4 performed the steps of removing Resident 107's soiled dressings, cleansing the wounds, and applying new dressings on August 22, 2024, from 9:41 AM through 10:16 AM, without donning an isolation gown.</p> <p>Interview with Employees 2 and 4 on August 22, 2024, at 10:16 AM confirmed that both Resident 103 and Resident 107 required EBP during their wound care; however, they did not gown for either resident to perform the wound care.</p> <p>The CDC (Centers for Disease Control) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007) revealed that contact (gown and glove use for all care) and standard (glove use only for care likely to contact bodily fluids) isolation precautions are required for multidrug-resistant organisms (MDROs, infections with bacteria that are resistant to multiple commonly used antibiotics; e.g., MRSA (Methicillin-resistant staphylococcus aureus), VRE (Vancomycin-resistant enterococcus), and ESBLs (bacteria that produces extended-spectrum beta-lactamase that is resistant to commonly used antibiotics), during active infection or colonization (presence of bacteria in the absence of symptoms).</p> <p>Observation of Resident 28's room on the Oak hallway on August 21, 2024, at 9:24 AM revealed a yellow PPE divider on the door with gowns and gloves, and a plastic bin in the hallway that contained an additional PPE supply. No visible sign indicated what precautions were necessary to enter Resident 28's room. No sign indicated that visitors should check with the nurse before entering Resident 28's room.</p> <p>Interview with Employee 8 (licensed practical nurse) on August 21, 2024, at 9:26 AM revealed that Resident 28 was diagnosed with ESBL in her urine and contact precautions were necessary for care. Employee 8 confirmed that there was no signage to indicate what level of isolation precautions was necessary for Resident 28.</p> <p>Observation of Resident 28's room doorway on August 21, 2024, at 9:31 AM (after the surveyor's questioning) revealed that the facility added a sign to indicate contact precautions were necessary.</p> <p>Clinical record review for Resident 28 revealed a laboratory report dated September 18, 2023, for a urine sample collected September 13, 2023, that indicated a urinary tract infection with ESBL Klebsiella Pneumoniae (bacteria resistant to commonly used antibiotics). The report stipulated that, This patient may require isolation. The laboratory report indicated that the bacteria in Resident 28's urine was resistant to cephalosporins (large group of antibiotics derived from a mold that kills bacteria).</p> <p>Nursing documentation dated September 18, 2023, at 5:16 PM revealed that the physician ordered oral Cefdinir (cephalosporin antibiotic), 300 milligrams (mg), twice daily, to treat Resident 28's urinary infection. The documentation indicated that Resident 28's family did not want the use of intravenous antibiotics.</p> <p>A physician's order active September 19, 2023, through October 19, 2023, instructed staff to implement contact transmission based precautions due to the ESBL in Resident 28's urine.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There were no laboratory reports in Resident 28's clinical record that indicated her urine no longer presented ESBL infection before the discontinuation of contact isolation precautions.</p> <p>Urinalysis laboratory reports dated December 10, 2023, and December 13, 2023, indicated that the multiple organisms in the collected specimen suggested that the sample was likely contaminated; or the resident was likely considered colonized (infected without symptoms).</p> <p>A physician's order dated March 22, 2024, instructed staff to implement EBP.</p> <p>Interview with the Nursing Home Administrator, the Director of Nursing, and Employee 3 (registered nurse/infection control prevention coordinator) on August 22, 2024, at 1:30 PM confirmed that the facility had no policy or acceptable standard (e.g., CDC guideline) that warranted downgrading Resident 28's isolation precautions from contact to enhanced barrier precautions.</p> <p>The facility policy entitled, Clostridium Difficile last reviewed without changes on January 20, 2021, revealed that Clostridium Difficile (C. Diff) is transmitted the fecal oral route. Steps toward prevention and early intervention, which include ongoing surveillance and increase awareness of symptoms and risk factors among staff, resident, and visitors. Residents with diarrhea associated with C. Diff are placed on contact precautions. Residents with diarrhea and suspected C. Diff are placed on contact precautions while awaiting laboratory results. Residents with C. Diff are placed in a private room (if available). If a private room is not available, residents will be cohorted with a dedicated commode for each resident.</p> <p>Clinical record review for Resident 30 revealed the following physician orders:</p> <p>16 French, 10 milliliter balloon Foley (urinary) catheter for a diagnosis of obstructive and reflux uropathy (blockage of the urinary system).</p> <p>Enhanced barrier precautions.</p> <p>Vancomycin 125 mg every 6 hours by mouth for Enterocolitis (bowel inflammation) due to Clostridium Difficile (C. Diff, bowel infection) from August 13, 2024, until August 20, 2024.</p> <p>Review of Resident 30's laboratory results dated [DATE], revealed that she was positive for C. Diff.</p> <p>Observation on August 20, 2024, at 9:32 AM and 12:30 PM and August 21, 2024, at 9:14 AM of the hallway outside Resident 30's room revealed that there was enhanced barrier precaution signage to indicate the need to utilize PPE (personal protective equipment, to prevent infectious disease transmission). There was no signage that indicated the need for contact isolation outside Resident 30's room. There was another resident located in Resident 30's room, but there was no commode noted in Resident 30's room for their individual use.</p> <p>This surveyor reviewed the above information during an interview on August 22, 2024, at 2:00 PM with the Nursing Home Administrator and the Director of Nursing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The CDC, Return to Work Criteria for HCP (health care personnel) with SARS-CoV-2 (COVID-19) Infection, stipulated that HCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised could return to work after the following criteria have been met:</p> <p>At least seven days have passed since the date of their first positive viral test if a negative viral test is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day five through seven).</p> <p>Review of Employee 5's (licensed practical nurse) personnel records revealed that she tested positive for COVID-19 on December 25, 2023. Review of Employee 5's work schedule revealed that she worked regular hours on December 25, 26, 28, 29, 30, and 31, 2023.</p> <p>Interview with Employee 3 and the Director of Nursing on August 22, 2024, at 1:11 PM confirmed the payroll records for Employee 5 indicated that she worked regular hours immediately following her positive COVID-19 testing. The interview also confirmed that the facility could not provide evidence of contact tracing (investigation to determine what resident(s) or staff may have been in contact with Employee 5 while she was positive for COVID-19 infection) or COVID-19 testing completed on other staff or residents in response to Employee 5's positive result.</p> <p>The CDC current Water Management Program Toolkit, Practical Guide to Implementing Industry Standards, indicated that many buildings need a water management program to reduce the risk for Legionella (bacteria that can grow and spread in water systems and can cause a serious type of pneumonia (lung infection) known as Legionnaires' disease) growing and spreading within their water system and devices. Developing and maintaining a water management program is a multi-step process that requires continuous review. Steps to building an effective Legionella water management program include:</p> <p>A description of the building's water system using flow diagrams and a written description to include details like connections to the municipal water supply, how water is distributed, and location of water heaters/boilers.</p> <p>Identification of potentially hazardous conditions such as areas where water temperature could promote Legionella growth or where water flow might be low.</p> <p>Control measures (such as heating, adding disinfectant, or cleaning) that include where and how to monitor them. Control limits are the maximum value, minimum value, or range of values that are acceptable for the control measure.</p> <p>Determine what corrective actions or contingency responses to take when control measures are outside the control limits established.</p> <p>The facility's, Legionella Water Management Program, last reviewed without changes on January 17, 2024, revealed that the water management program was comprised of elements that included: specific measures used to control the introduction and/or spread of legionella (e.g., temperature, disinfectants); the control limits or parameters that are acceptable and that are monitored; a diagram of where control measures are applied; a system to monitor control limits and the effectiveness of control measures; a plan for when control limits are not met and/or control measures are not effective; and the documentation of the program.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Employee 6 (maintenance director) on August 22, 2024, at 1:30 PM indicated that he had no documentation that the facility specified any control limits (e.g., water temperatures or concentration of disinfectants), that staff tested the effectiveness of any measures, or that the facility had a planned response should the findings indicate an ineffective water management program.</p> <p>The surveyor reviewed the concerns regarding the facility's water management program during an interview with the Nursing Home Administrator, the Director of Nursing, and Employee 3, on August 22, 2024, at 2:30 PM.</p> <p>An observation and interview of Resident 29 on August 20, 2024, at 9:24 AM revealed the resident lying in bed. An empty bed pan was observed directly on the floor, not covered, under the resident's bed. Resident 29 stated the bed pan was there exactly how she liked it. Resident 29 stated she is independent in taking herself to the bathroom with her walker, but at night she wants the bed pan there for emergencies. If she needs to use it, she reaches under the bed to get it, places it back on the floor, and then in the morning takes it into her bathroom to empty and clean it, stating she does not want to disturb anyone.</p> <p>Resident 29's care plan revealed an intervention for the use of diuretics noted that the resident may void in a basin, kept at bedside during the night per her preference, which was added on August 12, 2024, to the plan of care.</p> <p>Concerns of contamination with the bed pan being stored directly on the floor and proper cleaning of the used bed pan was reviewed with the Nursing Home Administrator and Director of Nursing on August 21, 2024, at 2:00 PM.</p> <p>Nursing documentation dated August 21, 2024, at 6:31 PM noted Resident 29 did not want to stray away from the routine of using the bed pan during the night and sliding it under her bed and the resident was educated on the potential infection control risk of storing the bed pan directly on the floor. It was noted the resident was given disposable pads to place the bed pan on top of and wrap over the top of the pan to limit contamination.</p> <p>A follow up observation of Resident 29 on August 22, 2024, at 12:22 PM revealed the resident was lying in bed. A disposable pad was observed folded in half on the floor in front of the resident's air conditioning unit. Resident 29's walker was parked on top of half the pad, with half sticking out in front of the walker toward the resident's bed. An empty bed pan was observed directly on the floor under the resident's bed. Upon interview, Resident 29 stated she did not know what the pad was for that was under her walker. When asked where she was keeping her bed pan, Resident 29 stated, Is it under the bed, Is it clean? I think I cleaned it. When Resident 29 was questioned if she was to put the bed pan on the pad, she the stated, I don't know, is that what I am supposed to do with it?</p> <p>There was no evidence staff was checking on the storage of Resident 29's bed pan, or assuring the bed pan was cleaned properly to prevent the potential for contamination/infection.</p> <p>The above findings regarding Resident 29 were reviewed with the Nursing Home Administrator and Director of Nursing on August 22, 2024, at 1:45 PM.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>(continued on next page)</p>		

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 08/23/2024
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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 201.18(b)(1)(3)(e)(1)(2.1) Management</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725</p> <p>Based on review of select facility policies and procedures, clinical record review, and staff and family interview, it was determined that the facility failed to ensure all residents who consented to the COVID-19 vaccine received the vaccine for three of five residents reviewed for immunizations (Residents 26, 28, and 107).</p> <p>Findings include:</p> <p>The facility policy entitled, Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures, last reviewed without changes on January 17, 2024, revealed that the facility follows infection prevention and control (IPC) practices recommended by the Centers for Disease Control and Prevention to prevent the transmission of COVID-19 within the facility. Measures include encouraging staff, residents, and visitors to remain up to date with all COVID-19 vaccine doses.</p> <p>The CDC (Centers for Disease Control) recommendations for COVID-19 vaccines (https://www.cdc.gov/vaccines/covid-19/downloads/COVID-19-immunization-schedule-ages-6months-older.pdf) indicate that for people [AGE] years of age and older should have one additional dose administered at least four months following the last recommended dose of 2023-24 COVID-19 Vaccine.</p> <p>Interview with Employee 3 (registered nurse, infection control prevention coordinator) on August 22, 2024, at 11:59 AM indicated that documentation regarding informed consent (following education regarding immunization risks and benefits) should be found under the admission documentation in the electronic medical record. The facility also maintains a binder of residents' consents for the influenza, pneumococcal, and COVID-19 vaccines.</p> <p>Clinical record review for Resident 26 revealed immunization documentation that the influenza and pneumococcal immunizations were refused. The electronic medical record did not include information regarding the COVID-19 vaccine.</p> <p>An Admission Document packet signed by Resident 26's son (power of attorney) on August 31, 2023, declined the administration of the influenza, pneumococcal, and COVID-19 vaccines. Documents signed by Resident 26's son on September 1, 2023 (the next day), consented to the administration of the pneumococcal and influenza vaccines. There was no documentation that Resident 26's son reviewed his decision to deny the administration of the COVID-19 vaccine when he changed his decision for the other vaccines.</p> <p>Interview with Employee 3 on August 22, 2024, at 12:17 PM, confirmed that there was no information for Resident 26 in the binder containing all facility residents' COVID-19 education and consent or declination to receive the vaccine.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Telephone interview with Resident 26's son on August 22, 2024, at 12:52 PM confirmed that he initially did not want his mother to receive immunizations; however, the next day, when he had time to think about the admission documents he signed, he decided to allow his mother to receive immunizations as per the recommended schedule. He confirmed that the September 1, 2023, consents were intended to give the facility permission to follow the recommended immunization schedule for the influenza, pneumococcal, and COVID-19 vaccines.</p> <p>Hospital documentation provided to the facility on [DATE], at 12:58 PM (following the surveyor's questioning) indicated that Resident 26 received her two-step Pfizer COVID-19 immunizations on April 30, 2021, and May 21, 2021. There was no evidence that she received any booster doses.</p> <p>The facility failed to ensure Resident 26 received a COVID-19 immunization as per her responsible party's wishes.</p> <p>Clinical record review for Resident 28 revealed an immunization history that she received her last COVID-19 booster on March 17, 2023.</p> <p>A COVID-19 SPIKEVAX Vaccine Consent signed by Resident 28's responsible party on August 1, 2024, indicated that the responsible party wanted Resident 28 to receive the COVID-19 vaccine.</p> <p>There was no evidence that Resident 28 received any COVID-19 immunizations for the 17 months after her March 17, 2023, COVID-19 booster.</p> <p>Clinical record review for Resident 107 revealed an immunization history that indicated he finished his COVID-19 two-step vaccination series on February 23, 2022.</p> <p>A COVID-19 SPIKEVAX Vaccine Consent signed by Resident 107 on June 19, 2024, indicated that he wanted to receive the COVID-19 vaccine.</p> <p>There was no evidence that Resident 107 received any COVID-19 booster immunizations after he consented to the immunization.</p> <p>Interview with Employee 3 on August 22, 2024, at 12:31 PM confirmed the above findings for Residents 28 and 107.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		