

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395602	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/19/2024
NAME OF PROVIDER OR SUPPLIER Wesley Village		STREET ADDRESS, CITY, STATE, ZIP CODE 209 Roberts Road Pittston, PA 18640	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</p> <p>Based on review of clinical records and staff interview, it was determined that the facility failed to timely consult with the physician regarding a significant weight gain displayed by one resident out of 24 sampled (Resident 12).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 12 was admitted into the facility on [DATE], with diagnoses to include heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and the presence of a cardiac pacemaker (device implanted in our body to deliver electrical impulses to your heart to help your heartbeat at a normal rate and rhythm).</p> <p>The resident had a physician order dated June 29, 2024, for staff to obtain a daily weight, one time a day, related to heart failure. If the resident was noted to experience a 3-pound weight gain in 24 hours or a 5-pound weight gain in 1 week, the physician was to be notified.</p> <p>A review of the resident's weight record revealed that the resident weighed 181.2 pounds on June 29, 2024. On June 30, 2024, it was noted that the resident weighed 190.4 pounds. The resident had a 9.2-pound weight gain in one day, which was a 5.08% weight gain.</p> <p>Review of a nutrition note dated June 30, 2024, at 11:02 AM, revealed that the dietitian indicated that the resident's weight was 190.4 pounds. She further stated that the resident had no decrease in food intake in the last 3 months, no weight loss in the last 3 months, and that the resident had suffered psychological stress or acute disease in the past 3 months.</p> <p>However, there was no documented evidence that the physician was notified of the resident's significant weight gain recorded on June 30, 2024.</p> <p>Continued review of Resident 12's weight record revealed that on July 1, 2024, the resident weighed 195.2 pounds. The resident had an additional 4.8-pound weight gain in 24 hours, which was another 2.52% weight gain, for a total of a 14-pound weight gain in 48 hours.</p> <p>There was no documented evidence that the physician was timely notified of the resident's continued weight gain recorded on July 1, 2024.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Nursing Home Administrator on July 18, 2024, at approximately 1:00 PM confirmed that the facility failed to timely notify the physician of the resident's significant weight gain recorded on June 30, 2024, and July 1, 2024.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing services</p>		

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<p>F 0584</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 a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944</p> <p>Based on observation, clinical record review and staff interview, it was determined that the facility failed to maintain a clean and sanitary environment for one resident out of 24 sampled (Resident 111).</p> <p>Findings include:</p> <p>A review of Resident 111's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included chronic pressure ulcers, dysphagia (difficulty swallowing) with use of a feeding tube [(enteral nutrition) uses a feeding tube to supply nutrients and fluids to the body when an individual cannot safely chew or swallow. Feeding tubes are soft, flexible plastic tubes through which liquid nutrition travels through the gastrointestinal (GI) tract] for primary means of nutrition and hydration.</p> <p>During observation of Resident 111's room on July 17, 2024, at 10:49 AM a pungent odor was detected. A plastic spoon and debris were observed underneath the resident's tube feeding pole. Dried tube feeding formula was observed splattered on the tube feeding pole and the carpeting below, which was sticky when walking on the surface.</p> <p>An interview with the Nursing Home Administrator (NHA) on June 17, 2024, at 2:15 p.m., confirmed that Resident 111's room was not maintained in a clean and sanitary environment.</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on review of clinical records and transfer notices, and staff interviews, it was determined that the facility failed to provide written notices of facility-initiated transfers to the resident and the resident's representative for one out of the 24 residents reviewed (Residents 69).</p> <p>Findings include:</p> <p>A review of the clinical record of Resident 69 revealed the resident was transferred to the hospital on May 29, 2024, and readmitted to the facility on [DATE].</p> <p>There was no documented evidence that the facility provided the resident and the resident's representative written notice of the transfer</p> <p>Interview with the Nursing Home Administrator and Assistant Director of Nursing on July 18, 2024, at approximately 11:30 AM, confirmed that the facility had no documented evidence that Resident 69 and the resident's representative were provided written notice of this facility-initiated transfer to the hospital.</p> <p>28 Pa. Code 201.29 (a)(c.3)(2) Resident rights</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on observation, clinical record review and staff interview, it was determined that the facility failed to timely develop and implement a person-centered care plan to meet one resident's current needs for the use of an implantable cardiac recording devices out of 24 sampled residents (Resident 69).</p> <p>Findings including:</p> <p>Clinical record review revealed that Resident 69 was admitted to the facility on [DATE], with diagnoses anxiety, seizures, and stroke.</p> <p>Documentation in the clinical record revealed that on October 1, 2023, Resident 69 had an implantable loop recorder (a small device placed just under the skin of the chest during a minor surgery which records the heartbeat continuously for up to three years. Device requires a transmitter at bedside to automatically send information from recorder to the health care provider).</p> <p>A review of the resident's current plan of care, initially dated October 1, 2023, revealed that the resident's care plan did not identify the presence of, or the care, for the resident's implantable loop recorder device.</p> <p>During an interview on July 19, 2024, at approximately 1:30 PM, the Director of Nursing confirmed that the implantable loop recorder was not addressed in the resident's plan of care.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing Services</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>48277</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of opioid pain medications prescribed on an as needed basis for one resident out of 24 residents reviewed (Resident 10).</p> <p>Findings include:</p> <p>A review of Resident 10's clinical record revealed a physician's order, initially dated June 24, 2024, and discontinued on July 1, 2024, for Hydrocodone-Acetaminophen 5-325 mg (an opioid pain medication combined with a non-opioid pain reliever used to treat moderate to severe pain), give one tablet by mouth every 4 hours as needed for numeric pain scale 6-10. There was also a physician's order initially dated July 1, 2024, and discontinued July 3, 2024, for Hydrocodone-Acetaminophen 5-325 mg, give one tablet by mouth every 6 ours as needed for pain 6-10.</p> <p>A review of the resident's June 2024, Medication Administration Record (MAR) revealed that staff administered doses of the prn hydrocodone-acetaminophen pain medication 14 times during the month of June 2024. Of the 14 doses given, all were administered with no non-pharmacological interventions attempted prior to administration to reduce the resident's pain.</p> <p>A review of the resident's July 2024, MAR revealed that staff administered doses of the prn hydrocodone-acetaminophen pain medication 5 times during the month of July 2024. Of the 5 doses given, 4 were administered with no non-pharmacological interventions attempted prior to administration.</p> <p>A physician's order, initially dated July 3, 2024, and discontinued July 6, 2024, for Oxycodone HCL 5 mg (a narcotic opioid pain medication), give 5 mg by mouth every 6 hours as needed for severe pain for pain level 6-10. Further, it was noted a physician's order dated July 8 2024, for Oxycodone HCL 5 mg, give one tablet by mouth every 6 hours as needed for pain 6-10.</p> <p>A review of the resident's July 2024, MAR revealed that staff administered doses of the prn oxycodone pain medication 26 times during the month of July 2024. Of the 26 doses given, 23 were administered with no non-pharmacological interventions attempted prior to administration to reduce the resident's pain.</p> <p>Interview with the Nursing Home Administrator and the Assistant Director of Nursing on July 19, 2024, at approximately 11:45 PM confirmed that there was no evidence that non-pharmacological interventions were consistently attempted and proved ineffective prior to administration of an as-needed pain medication.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929</p> <p>Based on observations, clinical record review and staff interviews, it was determined that the facility failed to ensure each resident timely received the necessary behavioral health care to attain or maintain the highest practicable mental and psychosocial well-being for one of 24 residents sampled (Resident 53).</p> <p>Findings include:</p> <p>Review of clinical record of Resident 53 revealed that the resident was admitted to the facility on [DATE], with diagnoses including anxiety.</p> <p>Resident 53's clinical record review also revealed that the resident exhibited multiple behaviors, including constant yelling out help me, help me and arguing with the resident's roommate.</p> <p>Documentation in Resident 53's clinical record revealed that the resident displayed an increase in these behaviors beginning June 2024, according to a review of progress notes. Progress notes indicated that the resident was almost daily asking for help even while staff were present providing help. During July 2024, progress note documentation revealed that the resident was upset that her roommate's privacy curtain was closed all the time. Resident 53's progress notes indicated she did not like when her roommates curtain was closed because it increased her anxiety. (Resident 53 resided in the window bed in their room).</p> <p>Review of Resident 53's most recent psychiatric consult, with an outside Licenced Clinical Social Worker, dated June 18, 2024, revealed that the resident that the consult did not address the resident's increased anxiety and behaviors of near constant yelling out. There was no indication that a potential room change was addressed with Resident 53 due to her dislike of roommate's preference for keeping the curtain closed.</p> <p>When reviewed during the survey ending July 19, 2024, there were no new or revised behavioral interventions developed for staff to employ added to the resident's care plan following the increase in behaviors beginning June 2024, to manage or modify the resident's behaviors of constant yelling out and the residents difficulty with her roommate, which were continuing through end of survey July 19, 2024.</p> <p>Interview with the Director of Nursing and Nursing Home Administrator on August 17, 2023, at approximately 1:30 PM were unable to provide evidence that Resident 53's behavioral health needs were met and services provided to manage or modify the resident's behaviors, to promote the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>28 Pa. Code: 201.29 (a)(b)(c) Resident Rights</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>48277</p> <p>Based on review of clinical records and controlled drug records, and staff interview, it was determined that the facility failed to implement procedures to promote accurate accounting of controlled medications for one of 24 residents sampled (Resident 10).</p> <p>Finding include:</p> <p>A review of the clinical record revealed that Resident 10 had a physician order dated June 24, 2024, for Hydrocodone-Acetaminophen 5-325 mg (an opioid pain medication combined with a non-opioid pain reliever used to treat moderate to severe pain), give one tablet by mouth every 4 hours as needed for numeric pain scale 6-10 (pain scale, 1-10, 1 least pain, 10 most pain).</p> <p>A review of the controlled substance record accounting for the above narcotic medication revealed that on June 28, 2024, at 4:15 PM, nursing staff signed out a dose of the resident's supply of Hydrocodone-Acetaminophen 5-325 mg. However, the administration of the controlled drug to the resident was not recorded on the resident's Medication Administration Record (MAR) on that date and time.</p> <p>A physician order dated July 1, 2024, was noted for Hydrocodone-Acetaminophen 5-325 mg, give one tablet by mouth every 6 hours as needed for pain for 14 days for pain scale 6-10.</p> <p>A review of the controlled substance record accounting for the above narcotic medication revealed that on July 3, 2024, at 8:00 PM, nursing staff signed out a dose of the resident's supply of Hydrocodone-Acetaminophen 5-325 mg. However, the administration of the controlled drug to the resident was not recorded on the resident's Medication Administration Record (MAR) on that date and time.</p> <p>A physician order dated July 3, 2024, was noted for Oxycodone HCL 5 mg (a narcotic opioid pain medication), give 5 mg by mouth every 6 hours as needed for severe pain for pain level 6-10.</p> <p>A review of the controlled substance record accounting for the above narcotic medication revealed that on July 5, 2024, at 8:15 PM, and July 6, 2024, at 2:13 PM, nursing staff signed out a dose of the resident's supply of Oxycodone 5 mg. However, the administration of the controlled drug to the resident was not recorded on the resident's Medication Administration Record (MAR) on those dates and times.</p> <p>A physician order dated July 8, 2024, was noted for Oxycodone HCL 5 mg, give one tablet by mouth every 6 hours as needed for pain 6-10.</p> <p>A review of the controlled substance record accounting for the above narcotic medication revealed that on July 11, 2024, at 2:34 PM, nursing staff signed out a dose of the resident's supply of Oxycodone 5 mg. However, the administration of the controlled drug to the resident was not recorded on the resident's Medication Administration Record (MAR) on that date and time.</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>During an interview on July 18, 2024, at approximately 1:45 PM, the Nursing Home Administrator confirmed the inconsistencies in the accounting and administration of the opioid pain medication for Resident 10.</p> <p>28 Pa Code 211.5 (f) Medical records</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p> <p>28 Pa Code 211.9(a)(1)(k) Pharmacy services</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on a review of clinical records and staff interviews it was determined that the facility failed to ensure that the resident's drug regimen was free of unnecessary antibiotic drugs for one out of 24 residents sampled (Residents 19).</p> <p>Findings included:</p> <p>Clinical record review revealed that Resident 19 was admitted to the facility on [DATE], with diagnoses to include chronic kidney disease, kidney stones, and heart disease, and was followed by Nephrology for management of nephrostomy tube (a thin, flexible tube that drains urine from the kidney through an opening in the skin on the back) placed prior to admission to the facility.</p> <p>Review of clinical record revealed emergency room evaluation report dated May 22, 2024, which indicated that the resident required replacement of the nephrostomy tube due to dislodgement. Following review by infectious disease, antibiotic therapy was stopped as resident's urine culture had ESBL and VRE colonized bacteria (harmless presence of microorganisms).</p> <p>Review of clinical record revealed documentation dated June 28, 2024, at 3:35 PM, revealed that Resident 19 informed the nurse that she was having irritation an[d] slight burning when voiding, stating she felt she had a urinary tract infection. The physician was contacted and ordered a urinalysis with culture and sensitivity. There was no documented evidence that the resident had experienced any further symptoms of a urinary tract infection such as fever, chills, mental changes/confusion, fatigue, nausea/vomiting, pressure in the lower part of pelvis, or increase in urination.</p> <p>Nursing documentation dated June 29, 2024, at 3:52 PM, indicated that the resident's urinalysis results were received and nursing called the covering physician with the results. The covering physician ordered Cefdinir (antibiotic) 300 mg twice a day for five days.</p> <p>Review of documentation dated July 1, 2024, revealed that the resident's attending physician discontinued the antibiotic previously ordered on June 29, 2024, and noted to wait for final urine culture and sensitivity result.</p> <p>Review of Resident 19's Medication Administration Records (MAR) dated June 2024 and July 2024 revealed that the resident received 4 doses of Cefdinir before it was discontinued and the resident's attending physician noted to wait for culture and sensitivity results.</p> <p>Review of urine culture and sensitivity report dated July 3, 2024, revealed that the organisms, previously identified as colonized, were resistant to treatment with the antibiotic Cefdinir.</p> <p>Interview with the Infection Preventionist on July 18, 2024, at approximately 11:00 AM, confirmed that the administration of Cefdinir was not clinically justified for treatment of Resident 19's UTI</p> <p>28 Pa. Code 211.2 (3) Medical Director</p> <p>28 Pa. Code 211.9 (k) Pharmacy Services</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to attempt a gradual dose reduction of psychoactive medications for one resident (Resident 44) and failed to clinically justify the increase of psychoactive medication for one resident (Resident 69) out of five sampled.</p> <p>Findings include:</p> <p>A review of Resident 44's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to include schizoaffective disorder and Parkinson's disease.</p> <p>The resident had a physician order initially dated September 2023, for Invega Trinza Intramuscular Suspension Prefilled Syringe 819 MG/2.63 ML (Paliperidone Palmitate - an atypical antipsychotic drug) Inject 2.63 mg/ml intramuscularly one time a day every 90 days for schizoaffective disorder.</p> <p>The resident also had a physician order dated September 2023, for Sertraline HCL (an antidepressant drug, brand name Zoloft) Oral Tablet 50 MG 1 tab daily for depression and Abilify 10 mg (an antipsychotic drug) 1 tab daily for schizoaffective disorder.</p> <p>A pharmacist consult to the physician dated March 19, 2024, revealed that the pharmacist requested that the physician attempt a gradual dose reduction of the Invega Trinza, Zoloft and Abilify.</p> <p>The physician's response was solely to defer to psychiatry with no explanation of the individualized clinical rationale of the necessity of continuing the current dosage each psychoactive drug in the resident' treatment.</p> <p>Further review of the resident's clinical record, conducted during the survey ending July 19, 2024, revealed no current psychiatry visits to provide the clinical rationale for the continued use of the above noted psychoactive medications.</p> <p>The facility was unable to provide documented evidence to support the resident's continued need for the current dosages of Invega, Sertraline, and Abilify or evidence that a gradual dose reduction was attempted for any of these psychoactive medications in the past year.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on July 17, 2024, at approximately 12:45 PM, these administrative staff members confirmed the lack of GDR attempts for the psychoactive drugs prescribed for Resident 44.</p> <p>Clinical record review revealed that Resident 69 was admitted to the facility on [DATE], with diagnoses to include major depressive disorder, stroke, and aphasia (difficulty with verbal communication).</p> <p>(continued on next page)</p>		

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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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A pharmacy review dated May 15, 2024, at 4:38 PM, revealed a recommendation to decrease the resident's Zyprexa (antipsychotic) to 2.5 mg. A physician order was received to decrease the dose of the antipsychotic medication in response.</p> <p>The resident's clinical record revealed documentation dated May 18, 2024, through May 22, 2024, noted that the resident had no change in mood or behavior noted from the medication reduction, no ill effects or behaviors related to decrease in medication, and the resident was pleasant and cooperative with care.</p> <p>Clinical record revealed documentation dated May 22, 2024, at 6:30 PM, revealed that Resident 69's son called to inform the facility that the resident called him, reporting not feeling well. According to the documentation, the resident told nursing staff that he had discomfort below right breast area, coming from his spine, which he had discomfort in the past and it resolved, and it's the same as he had in the past. Nursing assessment revealed that the resident's blood pressure was 167/93, heart rate 65, and respiratory rate was 18.</p> <p>A call was placed to the covering physician who ordered blood work in the morning and to increase Zyprexa to 5 mg daily (which had just been decreased to 2.5 mg on May 15, 2024).</p> <p>Review of Consultant Pharmacy Medication Review dated May 23, 2024, revealed that upon review from pharmacist, the resident's Zyprexa was decreased on May 15, 2024, to 2.5 mg daily and then increased back to 5 mg daily on May 23, 2024 however there is no documentation supporting the need for the increased dose. According to the pharmacist review, current documentation mentions that the resident is calm and pleasant, appears comfortable, cooperative to care, and no s/s [signs/symptoms] of anxious tendencies. The pharmacist requested supportive documentation to clinically justify the increase in the antipsychotic medication.</p> <p>There was no documented evidence from the prescriber practitioner of the clinical necessity for the increase in the antipsychotic medication, which was confirmed during interview with the Director of Nursing on July 18, 2024, at approximately 1:30 PM.</p> <p>28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services</p> <p>28 Pa. Code 211.2 (d)(3)(9) Medical Director</p> <p>28 Pa. Code 211.5 (f) Clinical records</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43944</p> <p>Based on observation, a review of select facility policy, and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department and two of three resident pantries.</p> <p>Findings include:</p> <p>Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food).</p> <p>The initial tour of the kitchen that was conducted with the facility's Director of Food and Nutrition Services on July 16, 2024, at 9:01 a.m., revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness:</p> <p>Observations of the inside of the walk-in refrigerator revealed that there was milk spilled underneath the shelves on which the milk was stored.</p> <p>A tour of the dish room area revealed that a significant amount of water was pooling on the floor throughout the around the area. A ceiling tile was bowed and gaps present near the vent. There was a red/brown colored substance splattered on ceiling tiles above the dish machine.</p> <p>Observation during the lunch tray line meal service revealed that the Speech Pathologist entered the kitchen area without a wearing a hairnet.</p> <p>Inside of the tray line reach-in refrigerator, there was a tray of approximately forty (40) 4-ounce cartons of Mighty Shakes that were not dated with a thaw date. The FSD confirmed that shakes were not properly labeled and should have included a use by date as per manufactures instructions (manufacture notes a 14-day shelf life after thawing).</p> <p>In the resident's main dining room, two white plastic cans, used for dirty linens, were coated with splattered substances on the outside of the cans.</p> <p>Observations of the East Unit Medication Room on June 17, 2024, at 10:30 a.m., revealed (13) Mighty Shakes and three (3) nutritional juice drinks that were not labeled or dated. Employee 1, a Licensed Practical Nurse (LPN), confirmed that the nutritional supplements were not properly labeled or dated with thaw, use by or discard dates.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a facility policy titled Use By - Dating Guidelines that was provided by the facility on July 17, 2024, indicated that frozen shakes should be labeled with a use by date of fourteen days once thawed, and the day of preparation or opening is considered Day 1 in the use by date. Guidelines apply, regardless of storage location (e.g., kitchen, pantries, etc.).</p> <p>An interview with the Nursing Home Administrator (NHA) on July 17, 2024, at 2:00 p.m., confirmed that sanitary practices should be maintained for labeling supplements and the kitchen areas to prevent foodborne illness.</p> <p>28 Pa. Code 201.18 (e) (2.1) Management</p> <p>28 Pa. Code 211.6 (f) Dietary Services</p>		