

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Spiritrust Lutheran the Village at Sprenkle Drive		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Folkemer Circle York, PA 17404	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48484</p> <p>Based on facility policy review, observations, and resident and staff interviews, it was determined that the facility failed to ensure that five residents have the right to a dignified dining experience during meal service in one of one dining rooms observed (Residents 9, 17, 24, 35, and 64).</p> <p>Findings include:</p> <p>Review of facility policy, titled Residents Rights Standard, read, in part, All residents in long term care maintain the same rights assured all Americans under Federal and State law. This standard is intended to assure each resident's right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the center.</p> <p>Observations in the main dining room on November 3, 2024, between 11:34 AM and 12:02 PM, revealed Employee 4 (Dietary Employee) was serving tables throughout the dining room without completing one table at a time. The following observations were also made in the dining room during that time:</p> <p>Observation on November 3, 2024, at 11:34 AM, revealed Resident 26 was sitting at a table with Resident 35. Resident 26 had been previously served but Resident 35 was sitting without food, and Employee 4 was serving other tables.</p> <p>Observation on November 3, 2024, at 11:35 AM, Resident 35 was observed to state to Employee 4 could you get me something to eat please?</p> <p>During an interview with Resident 35 on November 3, 2024, at 11:37 AM, she revealed she is never sure when and if she is going to be served when she eats in the dining room. Resident 35 was observed to be served at 11:40 AM.</p> <p>Observation on November 3, 2024, at 11:34 AM, revealed Residents 17 and 56 were sitting at a table together, and Resident 56 had been previously served. Resident 17 was observed to be served at 11:42 AM.</p> <p>Observation on November 3, 2024, at 11:34 AM, revealed Residents 9, 27, and 46 were sitting at a table together, Resident 27 and 46 had been previously served.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on November 3, 2024, at 11:40 AM, revealed Resident 9 was observed to state where is my meal? I have been here since 11:00 AM. Resident 9 was observed to be served at 11:43 AM.</p> <p>Observation on November 3, 2024, at 11:36 AM, revealed Residents 2, 37, and 64 were sitting at a table together, Resident 2 and 37 had been previously served.</p> <p>Observation on November 3, 2024, at 11:43 AM, revealed Resident 64 was observed to state to Employee 10 did you fix mine yet? Resident 64 was observed to be served at 11:45 AM.</p> <p>Observation on November 3, 2024, at 11:35 AM, revealed Residents 3, 24, and 28 were sitting at a table together, Resident 3 and 28 had been previously served. Resident 24 was observed to be served at 11:53 AM.</p> <p>During an interview with the Nursing Home Administrator on November 4, 2024, at 1:39 PM, she revealed her expectation that residents would be served considering dignity during meal service.</p> <p>28 Pa Code 201.29(d) Resident Rights</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>33879</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to accurately assess the dental status of one of two residents reviewed for dental services (Resident 64).</p> <p>Findings include:</p> <p>Review of Resident 64's clinical record revealed diagnoses which included atrial fibrillation (irregular heartbeat) and congestive heart failure (decreased ability of the heart to pump blood through the body).</p> <p>During a resident interview on November 4, 2024, it was observed that Resident 64 appeared to have no natural teeth.</p> <p>Review of a physician assessment conducted on October 10, 2024, revealed the physician noted Resident 64 was edentulous (without teeth).</p> <p>Review of Resident 64's Admission Minimum Data Set (MDS - standardized assessment utilized to identify a residents' physical, psychological, and psychosocial needs), with an assessment reference date of October 4, 2024, revealed that section L - Oral/Dental Status, was not accurately coded for L0200 Dental, B. No natural teeth or tooth fragments (edentulous).</p> <p>During a staff interview on November 6, 2024, at approximately 10:30 AM, Nursing Home Administrator and Director of Nursing confirmed that Resident 64 did not have any natural teeth and that Resident 64's Admission MDS was coded incorrectly.</p> <p>28 Pa code 211.12(d)(5) Nursing services</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>33879</p> <p>Based on observation, clinical record review, policy review, and resident and staff interviews, it was determined that the facility failed to develop and implement a comprehensive person-centered plan of care for four of 19 residents reviewed (Residents 44, 48, 57, and 64).</p> <p>Findings Include:</p> <p>A review of the facility's policy, titled Comprehensive Care Planning Standard, revised November 15, 2017, read Each .center will develop a comprehensive care plan for each resident that includes their strengths, measurable objectives and timetables. Goal is to meet a resident's medical, nursing (physical/symptom control), mental, intellectual, emotional, social, spiritual, psychosocial and cultural needs that are identified during baseline care</p> <p>planning and in the comprehensive assessment. Care Plans are formatted in the 'I Care Plan' format to ensure resident centered/resident directed living.</p> <p>Review of Resident 44's clinical record revealed diagnoses that included chronic venous hypertension with ulcer of the left and right lower extremity (damage to veins that prevent blood from flowing back to the heart causing increased blood pressure, ulcers, swelling, and pain in the legs) and type two diabetes mellitus (the bodies inability to use insulin to process blood sugar for energy).</p> <p>Review of Resident 44's physician orders revealed orders for bilateral lower extremity ace wraps for edema (swelling) to be applied in the morning and taken off at night. Further review of Resident 44's physician orders also revealed orders for spironolactone (diuretic used to help the body remove excess fluid) and furosemide (diuretic used to help the body remove excess fluid) once daily for edema.</p> <p>Review of Resident 44's comprehensive plan of care failed to revealed focus areas or interventions for edema, bilateral leg wraps, and diuretic use.</p> <p>An email communication on November 6, 2024 at 9:11 AM, with the Nursing Home Administrator (NHA), revealed Resident 44's comprehensive plan of care should have been updated to include edema, bilateral legs wraps, and diuretic use and that a revision had been done.</p> <p>A review of Resident 48's clinical record revealed diagnoses that included bilateral cataracts (a clouding of the lens inside the eye, which normally is clear, causing blurry or cloudy vision due to the obstruction of light passing through to the retina; cataracts are most commonly associated with aging and can lead to blindness if left untreated) and hypertension (elevated blood pressure).</p> <p>An interview with Resident 48 on November 3, 2024, at 10:01 AM, revealed she needed cataract surgery and is awaiting the surgery to be scheduled.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 48's interdisciplinary plan of care revealed no documentation of the Resident's visual function, bilateral cataracts, or staff interventions to assist the Resident with her visual function as needed.</p> <p>Electronic mail correspondence with the Nursing Home Administrator (NHA) on November 5, 2024, at 2:42 PM, revealed a vision care plan for Resident 48 was created and had now been added to the Resident's clinical record.</p> <p>A review of Resident 57's clinical record revealed diagnoses that included muscle weakness, abnormality of gait (a person's manner of walking), and mobility (the ability to move or be moved freely and easily).</p> <p>An observation of Resident 57 while in bed revealed bilateral enabler bars attached to the bed.</p> <p>A review of Resident 57's device review evaluation dated October 31, 2024, revealed the need for the use of the enablers for bed mobility.</p> <p>A review of Resident 57's interdisciplinary plan of care revealed no documentation of the Resident's need or use of those bilateral enabler bars.</p> <p>An interview with the facility's Corporate Excellence Nurse on November 6, 2024, at 10:36 AM, revealed no enabler care plan was in place, but has now been developed and added to the Resident's clinical record.</p> <p>A review of Resident 64's clinical record revealed diagnoses which included atrial fibrillation (irregular heartbeat) and congestive heart failure (CHF - decreased ability of the heart to pump blood through the body).</p> <p>During a resident interview on November 4, 2024, it was observed that Resident 64 appeared to have no natural teeth.</p> <p>A review of a physician assessment conducted on October 10, 2024, revealed the physician noted Resident 64 was edentulous (without teeth).</p> <p>A review of Resident 64's comprehensive plan of care revealed no dental care plan identifying that the Resident had no natural teeth.</p> <p>During a staff interview on November 6, 2024, at approximately 11:45 AM, the NHA confirmed that Resident 64's comprehensive plan of care did not include a care plan that addressed Resident 64's dental status of lacking natural teeth.</p> <p>28 Pa. Code 211.12 (d) (5) Nursing services</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>49123</p> <p>Based on observations, clinical record review, and resident representative and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for one of 19 residents reviewed (Resident 61).</p> <p>Findings include:</p> <p>Review of Resident 61's clinical record revealed diagnoses that included Parkinson's disease (progressive brain disorder that causes unintended or uncontrolled movements) and lack of coordination (difficulty controlling movements of the body).</p> <p>During an interview on November 3, 2024 at 10:37 AM, with Resident 61's Responsible Party, it was revealed that Resident 61 used an electric recliner and that the facility had taken the remote, preventing Resident 61 from being able to recline when sitting in the chair.</p> <p>Review of Resident 61's comprehensive plan of care revealed a focus area for impaired function of daily living due to Parkinson's with an intervention to recline chair and to put adjusting remote in pouch to chair.</p> <p>During an interview on November 5, 2024 at 12:15 PM, with the Director of Nursing (DON), it was revealed that Resident 61 recently had a fall after sliding out of the recliner due to not being able to work the remote and put the footrest down independently when reclined. The DON also revealed that due to Resident 61's cognitive level and inability to independently operate the chair's remote, that reclining Resident 61's chair would be considered a restraint and the remote was removed.</p> <p>An email on November 5, 2024 at 4:43 PM, from the NHA revealed that Resident 61's comprehensive plan of care should have been updated to reflect elevating Resident 61's legs as needed and removing the chair's remote from the room for safety. The NHA stated a care plan revision would be done.</p> <p>42 CFR 483.21(b) Comprehensive Care Plans</p> <p>28 Pa. Code 211.11(d)(e) Resident care plan</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>48484</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observations, select facility meal ticket review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, during meal service, for five of 20 residents in one of one dining rooms observed (Resident's 3, 11, 27, 37, 45).</p> <p>Findings include:</p> <p>Observation of Resident 3 in the main dining room on November 3, 2024, between 11:34 AM and 11:39 AM, revealed she was sitting at a table with her food sitting in front of her not eating.</p> <p>Review of Resident 3's meal tickets revealed she requires full assistance with her meals; Employee 5 (Registered Nurse), was observed to sit down and start providing feeding assistance to Resident 3 at 11:39 AM.</p> <p>Observation in the main dining room on November 3, 2024, at 11:42 AM, revealed Resident 11 was served her meal by Employee 4 (Dietary Employee) and was sleeping.</p> <p>Review of Resident 11's meal tickets revealed she requires full assistance with her meals; Employee 3 (Nurse Aide), was observed to start providing feeding assistance to Resident 11 at 11:55 AM.</p> <p>Observation in the main dining room on November 3, 2024, between 11:37 AM and 11:57 PM, revealed Resident 27 was not eating the food she had been served.</p> <p>Further observation in the dining room on November 3, 2024, at 11:58 AM, revealed Employee 10 cued Resident 27 to pick up her silverware and eat her meal.</p> <p>Review of Resident 27's meal tickets revealed she requires supervision at meals.</p> <p>Review of Resident 27's clinical record revealed she has sometimes required staff to provide cueing during meals or full feeding assistance over the past fourteen days due to a noted decline.</p> <p>Observation in the main dining room on November 3, 2024, between 11:36 AM and 11:40 AM, revealed Resident 37's food was sitting in front of her and she was repeating What do I do?</p> <p>Observation of Employee 11 on November 3, 2024, at 11:40 AM, revealed she walked up to Resident 37 and stated, You have a peanut butter and jelly sandwich. Employee 11 started unwrapping Resident 37's silverware and cued her to pick up the sandwich.</p> <p>Review of Resident 37's meal tickets revealed she requires set-up assistance at meals.</p> <p>Review of Resident 37's clinical record revealed she had required oversight, encouragement, or cueing in four of the past 14 days, including that day at lunch.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation in the main dining room on November 3, 2024, at 11:42 AM, revealed Resident 45 had been served, and was asking if someone was going to help her.</p> <p>During an interview with Resident 45 on November 3, 2024, at 11:44 AM, she revealed she needs help at her meals to eat.</p> <p>Review of Resident 45's meal tickets revealed she requires full assistance with her meals; Employee 3 (Nurse Aide), was observed to start providing feeding assistance to Resident 45 at 11:48 AM.</p> <p>During an interview with the Nursing Home Administrator on November 4, 2024, at 1:39 PM, she revealed her expectation that residents should be provided eating assistance, supervision, and cueing as required; and residents should not be served who require feeding assistance until nursing is ready to help them.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa Code 211.12 (c)(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>34631</p> <p>Based on clinical record review, policy review, and staff interview, it was determined that the facility failed to ensure a resident with limited range of motion receives the appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one of one resident reviewed for range of motion services (Resident 57).</p> <p>Findings Include:</p> <p>A review of Resident 57's clinical record revealed diagnoses that included muscle weakness, abnormality of gait (a person's manner of walking), and mobility (the ability to move or be moved freely and easily).</p> <p>A review of the facility's policy, titled Restorative Program Standard, revised July 23, 2015, described its purpose: Nursing team members direct and provide the service with input and support from the Nursing Department/Therapy Department to increase or preserve the highest level of self-performance of residents as appropriate.</p> <p>Restorative Nursing is defined as nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.</p> <p>A review of Resident 57's Occupation Therapy discharge summary dated October 16, 2024, revealed recommendations that included Restorative Range of Motion Program. Also, BUE [bilateral upper extremities] AROM [active range of motion] of shoulders, elbows, wrists, and fingers x 15 reps x3.</p> <p>A review of Resident 57's clinical record revealed no documentation of the restorative nursing program or staff implementing or providing the recommended active range of motion activities by the Occupational Therapist.</p> <p>An interview with the Nursing Home Administrator on November 6, 2024, at 10:39 AM, revealed the restorative nursing program was not implemented for Resident 57 upon discharge from occupational therapy on October 16, 2024, and will now be implemented by staff going forward.</p> <p>28 Pa. Code 211,12 (d) (1) (2) (3) (5) Nursing services</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>33879</p> <p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on facility policy review, clinical record review, observation, and staff interviews, it was determined that the facility failed to provide nutritional supplements as ordered by the physician for one of six residents observed during medication administration observations (Resident 4), and failed to notify the physician of a significant weight change for one of five residents reviewed for nutrition (Resident 54).</p> <p>Findings include:</p> <p>Review of facility policy, titled Weight Record Monitoring, last revised August 2024, read, in part, The physician and resident's responsible party are notified by the RD/designee of significant weight change (gain or loss) and of the IDT recommendations that would require further intervention/securing of new orders from the physician for the resident.</p> <p>Review of Resident 4's clinical record revealed diagnoses that included dementia (irreversible, progressive degenerative disease of the brain that results in decreased contact with reality and decreased ability to perform activities of daily living) and diabetes type II (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment).</p> <p>Review of Resident 4's physician orders revealed an order dating March 18, 2024, for a dietary supplement (house supplement) three times a day, 4 ounces, between meals for the indication of poor meal intake.</p> <p>During medication observations conducted on November 5, 2024, at approximately 10:00 AM, Employee 9 was observed preparing medications for Resident 4.</p> <p>During preparation, Employee 9 was observed pouring approximately 8 ounces of chocolate milk in a cup. Employee 9 then stated, I usually give chocolate milk instead of the shake, the nutritional shake, because [the residents] usually like it more.</p> <p>Review of the nutritional value of the chocolate milk revealed the chocolate milk did not offer an equivalent nutritional value when comparable to the house supplement that Resident 4 was ordered.</p> <p>During a staff interview on November 5, 2024, at approximately 10:30 AM, Nursing Home Administrator (NHA) revealed that chocolate milk should not have been used as a substitute to the house supplement that Resident 4 was ordered.</p> <p>Review of Resident 54's clinical record revealed diagnoses that included dysphagia (difficulty swallowing), muscle weakness, and Alzheimer's disease (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning).</p> <p>Review of Resident 54's clinical record revealed she had a significant weight loss of 5.7% in one month from September to October 2024.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident 54's clinical record revealed a nutrition assessment in response to the weight loss that stated Medical Doctor to be notified.</p> <p>During an email correspondence with the NHA on November 4, 2024, at 12:17 PM, the surveyor requested information related to a physician notification of Resident 54's weight loss.</p> <p>Follow-up interview with the NHA on November 5, 2024, at 10:28 AM, revealed she is unable to locate any documentation to indicate the physician was notified of the weight loss, that her last physician assessment was prior to the noted weight loss, and she would expect that documentation to be available.</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>48484</p> <p>Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of 18 Residents reviewed (Resident 12).</p> <p>Findings include:</p> <p>Review of Facility Policy, titled Trauma Informed Care Standard, with an effective date of November 1, 2019, read, in part, Definition: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social and emotional, or spiritual well-being. Events- can include actual or extreme threat or harm, or severe, life-threatening neglect for a child. Factors include: How an individual assigns meaning to the event. For residents: Initial screening on admission and with plan of care review, to determine if there may be a history of trauma. (See Getting to know our residents or guest form #8-204A). If identified, follow-up screening will occur to support development of the plan of care.</p> <p>Review of Resident 12's clinical record revealed diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things), anxiety disorder (a persistent feeling of worry, nervousness, or unease), and muscle weakness.</p> <p>During an interview with Resident 12 on November 3, 2024, at 11:22 AM, she was discussing her history of her career, but then started to become tearful as she stated she experienced childhood trauma.</p> <p>Review of Resident 12's care plan failed to reveal notification of having a history of trauma.</p> <p>Further review of Resident 12's care plan revealed she had a care plan focus area for depression and anxiety, with an intervention to arrange for psychiatric or psychological consult, follow up as indicated, with a start date of December 13, 2022.</p> <p>During an email correspondence with the Nursing Home Administrator (NHA) on November 3, 2024, at 12:57 PM, the surveyor revealed her interview with Resident 12 regarding her trauma, and requested information if that had been previously assessed, and if she follows with psychology services.</p> <p>Review of Resident 12's Psychosocial Assessment document provided dated December 13, 2022, failed to reveal questions regarding if the Resident had experienced a history of trauma, other than Describe significant life events over the past year.</p> <p>Review of Resident 12's PsychoGeriatric Services notes provided from May 22, 2024, and September 17, 2024, failed to reveal notation of a history of trauma.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Spiritrust Lutheran the Village at Sprenkle Drive		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 Folkemer Circle York, PA 17404	

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the NHA and Employee 6 (Social Services Director) on November 5, 2024, at 10:28 AM, the surveyor inquired if there are any PsychoGeriatric Services assessing her history of trauma, or if the form mentioned in the facility policy is utilized the assess a history of trauma for residents upon admission.</p> <p>Interview with the NHA and Employee 6 on November 6, 2024, at 10:31 AM, revealed they are unable to locate documentation to indicate Resident 12 was assessed for her history of trauma.</p> <p>Follow-up email correspondence with the NHA on November 7, 2024, at 9:23 AM, revealed the facility is moving away from utilizing the form mentioned in the trauma informed care policy, they instead use a different form titled Psychosocial Assessment that assesses for a history of trauma. No further information was provided.</p> <p>28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services</p> <p>28 Pa Code 211.10(a) Resident care policies</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48484</p> <p>Based on facility policy reviews, observations, and staff interviews, it was determined that the facility failed to store food and utilize kitchen equipment in accordance with professional standards for food service safety in the main kitchen and one of one nourishment area.</p> <p>Findings include:</p> <p>Review of facility policy, titled Labeling and Dating of All Food Products, not dated, read, in part, Each label must contain the following information: Product name or common name or identifying description, use by date, date the product was prepared or opened, date thawed, if applicable. When a product is removed from the box the individual items must be labeled individually.</p> <p>Review of facility policy, titled Maximum Storage Period of Dried Goods, last revised [DATE], read, in part, Flour and spices that are opened are good for six months.</p> <p>Review of facility policy, titled Storage of Refrigerated & Frozen Foods, last revised [DATE], read, in part, [NAME] onions and cut-up cooked poultry have a maximum storage period of up to 7 days, and ReadyCare Frozen Shakes that are thawed and unopened are good for up to 14 days.</p> <p>Observation of the dry storage area on [DATE], at 9:37 AM, revealed: a bin of breadcrumbs labeled use by [DATE]; three bags of hamburger buns labeled use by [DATE]; one bag of hamburger buns labeled use by [DATE]; one bag of dinner rolls not dated; one sugar bin not labeled or dated; one flour bin labeled use by [DATE]; two boxes of fudge brownie mix not dated; one bag of sliced almonds open with a use by date of [DATE]; one bag of cane sugar labeled use by [DATE]; and one can of pimentos not dated.</p> <p>Observation in the main kitchen on [DATE], at 9:50 AM, revealed one case of bananas that were black and some had started to peel open; and one container of brown sugar not labeled or dated.</p> <p>Observation of reach in refrigerator 1 on [DATE], at 9:54 AM, revealed an individual covered side dish not labeled or dated, further observation when uncovered revealed moldy slices of cut watermelon; and one ReadyCare Frozen Shake that was thawed without a thawed date.</p> <p>Observation of the walk in refrigerator on [DATE], at 9:59 AM, revealed two bags of deli turkey labeled they were sliced on [DATE], and had a use by date of [DATE]; one contained of seafood salad labeled use by [DATE]; one bag of green onions not labeled with a use by date, further observation revealed most of them were dark green and wilted and were received at the facility [DATE].</p> <p>Observation in the main kitchen on [DATE], at 10:08 AM, revealed one container of whole celery seed with an open date of [DATE]; one open container of dill with an open date of [DATE]; and one open container of nutmeg with an open date of [DATE]; further observation of the spice rack revealed 23 containers of spices labeled with a use by date of one year from opening.</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>Observation of the three-compartment sink in the main kitchen on [DATE], at 10:29 AM, revealed Employee 2 (General Dietary Manager) tested the concentration (unit of measure) of the sanitizer water utilizing a test strip that had an expiration date of February 1, 2023.</p> <p>Observation of the skilled pantry area refrigerator on [DATE], at 10:34 AM, revealed five Readycare Frozen Shakes that were thawed without a thawed date; nine yogurts labeled use by [DATE]; one container of thickened lemon water open without an open date; one container of thickened cranberry juice open without an open date; one container of thickened orange juice open without an open date; and one container of regular orange juice open without an open date.</p> <p>Interview with Employee 2 on [DATE], at 10:41 AM, revealed the expectation of storing food and utilizing equipment considering foodservice safety and in accordance with professional standards.</p> <p>Interview with the Nursing Home Administrator on [DATE], at 1:38 PM, revealed it was the facility's expectation that expired items are discarded, foods items are labeled and dated per facility policy, and food items and kitchen equipment are stored and utilized in accordance with professional standards.</p> <p>28 Pa. Code 211.6(f) Dietary services</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>33879</p> <p>Based on staff interview and available documentation review, it was determined that the facility administration failed to ensure care policies were reviewed and approved by the administration and Medical Director yearly.</p> <p>Findings include:</p> <p>During an entrance staff interview on November 3, 2024, at approximately 10:20 AM, a request was made of the Nursing Home Administrator (NHA) to provide evidence that the facility's care policies had been reviewed and approved within the past year.</p> <p>In an electronic communication on November 5, 2024, at 2:56 PM, NHA revealed the facility was unable to locate a signatory page indicating the last care policy review date.</p> <p>Review of the care policy review binder that was stored near the nurses station, provided by the Director of Nursing (DON), on November 6, 2024, at approximately 9:45 AM, revealed the signatory page confirming that the NHA, DON, and Medical Director had reviewed and approved of the care policies was dated March 9, 2022.</p> <p>As of November 6, 2024, at 11:45 AM, the facility had no further information or evidence to provide regarding conducting a care policy review within the last year of the survey.</p> <p>28 Pa code 201.18(d) Management</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>33879</p> <p>Based on review of Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) staffing data report and staff interview, it was determined that the facility failed to electronically submit direct care staffing information for one of one quarters reviewed (FY Quarter 3 - April 1, 2024, to June 30, 2024).</p> <p>Findings include:</p> <p>According to Section 6106 of the Affordable Care Act (ACA), facilities are required to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. The data, when combined with census information, can then be used to report on the level of staff in each nursing home, as well as employee turnover and tenure, which can impact the quality of care delivered.</p> <p>Review State Operations Manual, under section 483.70(q), revealed Mandatory submission of staffing information based on payroll data in uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. Under section 483.70(q)(4), The facility must submit direct care staffing information in the uniform format specified by CMS. Under section 483.70(q)(5), The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.</p> <p>Review of PBJ staffing data reports for fiscal year third quarter 2024 revealed the facility triggered for Failed to Submit Data for the Quarter.</p> <p>During a staff interview on November 5, 2024, at approximately 10:30 AM, Nursing Home Administrator revealed the submission would have been conducted by a prior administration and was unaware if the submission to PBJ was completed or not.</p> <p>As of November 6, 2024, at 11:45 AM, the facility had no further information to provide.</p> <p>28 Pa. Code 201.18(a) Management</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49123</p> <p>Based on review of facility policy, observations, and staff interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of four residents on transmission-based precautions (Residents 61).</p> <p>Findings include:</p> <p>Review of facility policy, titled Transmission Based Precautions, with a revision date of June 2024, read, in part, I. Enhanced Barrier Precautions (EBP): is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of S. aureus and MDROs. G. Enhanced Barrier Precautions b. EBP may be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: i. Wounds or indwelling medical devices, regardless of MDRO colonization status . g. gowns and gloves required when performing high-contact resident care activities associated with MDRO transmission (e.g. dressing, bathing, showering, toileting, transferring, changing linens, etc.).</p> <p>Review of Resident 61's clinical record revealed diagnoses that included parkinsons's disease (chronic, progressive brain disorder that affects movement and other parts of the body) and muscle weakness (loss of muscle strength).</p> <p>Review of Resident 61's physician orders revealed orders for wound care and enhance barrier precautions (EBP).</p> <p>An observation on November 3, 2024, at 10:34 AM, of Resident 61's room revealed signage indicating EBP and a personal protective equipment (PPE) caddy containing gowns and gloves.</p> <p>Observations made on November 6, 2024, at 9:45 AM, of Resident 61's wound care and dressing change revealed Employee 7 and Employee 8 failed to don gowns while performing high-contact Resident care.</p> <p>During an interview on November 6, 2024, at 10:00 AM, with Employee 7, revealed that Resident 61 is on EBP and gowns should have been worn.</p> <p>An interview on November 6, 2024, at 10:40 AM, with the Nursing Home Administrator, Director of Nursing, and Employee 1, revealed it was the facility's expectation that employees wear appropriate PPE.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services</p> <p>28 Pa. Code 211.10 (d) Resident care policies</p>		