

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395613	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Laurel Lakes Rehabilitation and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Franklin Farm Lane Chambersburg, PA 17201	

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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>33305</p> <p>Based on review of facility policy, closed clinical record, resident account statement and staff interview it was determined that the facility failed to convey resident account balance in accordance with State law and closed accounts upon discharge in a timely manner for one of 2 closed resident records, Resident 12.</p> <p>Findings include:</p> <p>A review of the facility policy titled, Account Receivable Refunds, last revised May 5, 2023, states, Credit balances to be refunded after researching for validity. Private pay credit balances/overpayment are to be refunded within 30 days.</p> <p>The facility confirmed that on May 17, 2024, complainant paid on the Resident 12's account to cover May 1, 2024, through May 31, 2024.</p> <p>Review of the closed clinical record for Resident 12, revealed resident was discharged from the facility on May 24, 2024.</p> <p>Complainant states that she has contacted the facility several times to request a refund, without success of receiving the refund.</p> <p>Review of Resident 12's account indicated that the complainant should have received a refund in the amount of \$2,424.00 (two thousand, four hundred, twenty-four dollars).</p> <p>During an interview with the Nursing Home Administrator (NHA) on October 17, 2024, at 9:15 AM the NHA was aware that refunds on account balances should occur within thirty days and when ask why the balance wasn't refunded the NHA replied, It has to go through corporate for approval. The NHA also confirmed that payer of Resident 12's account is calling weekly requesting the refund. The NHA added that he contacted the facility's corporate office on October 18, 2024, and was informed the refund check will be dispersed on this date.</p> <p>28 Pa. Code 211.5(d) Clinical records.</p> <p>28 Pa Code: 201.18(e)(1) Management.</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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305</p> <p>Based on clinical record review, hospital record review, and staff interviews, it was determined that the facility failed to ensure care and services were provided after a change in condition for one of 20 residents reviewed (Resident 1). This failure resulted in continued decline, which required hospitalization for septic shock (a widespread infection causing organ failure and dangerously low blood pressure) and death. This failure placed an additional 10 out of 20 residents reviewed who were identified as having a change in condition in an immediate jeopardy situation (Residents 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11).</p> <p>Findings include:</p> <p>The facility has a policy regarding change in condition, but does not have a specific policy or documented process for alert charting for residents that are initially assessed to have a change in condition.</p> <p>Review of Resident 1's clinical record revealed diagnoses that included Hypertension (above normal blood pressure), Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and Displaced Bimalleolar Fracture of right lower leg (severe injury that occurs when both the medial and lateral malleolus bones in the ankle are broken and displaced).</p> <p>Review of Resident 1's Admission MDS (Minimum Data Set- periodic assessment of the resident) dated [DATE], revealed a BIMS (brief interview of mental status) of 12, indicating cognitive status is moderately impaired. A score of ,d+[DATE] is moderately impaired and ,d+[DATE] is cognitively intact.</p> <p>Review of Resident 1's clinical record revealed a diagnosis of COVID-19 on [DATE], and on [DATE], documentation revealed Resident 1 had poor meal intake since COVID-19. Resident 1's quarterly MDS dated [DATE], now revealed a BIMS of 7, indicating severe cognitive impairment.</p> <p>On [DATE], Employee 1 (Registered Nurse) who was covering as the supervisor, was called to assess Resident 1 after a family member visiting stated concerns about Resident 1 having a headache and dry lips. The family member also requested that a urine sample be obtained so that a urinary tract infection could be ruled out.</p> <p>During a phone interview with the family member on [DATE], at 6:45 PM, she stated she had concerns for Resident 1 because she kept falling asleep and confirmed that she asked the nurse to do a urine test on Resident 1. The family member also stated that when she questioned the reason for Resident 1's dry lips, Employee 1 informed her that Resident 1 is probably dehydrated.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview with Employee 1 on [DATE], at 11:00 AM, Employee 1 stated that she didn't remember Resident 1. Employee 1 was asked about alert charting; Employee 1 was aware that residents are placed on alert charting for a change in condition. Employee 1 stated that the alert charting process keeps changing, sometimes resident's names are entered in a logbook and sometimes entered in the clinical record under the forms tab. Employee 1 was unaware that alert charting must be entered into the electronic medical record by administrative staff so that it automatically populated to an area in the treatment administration record.</p> <p>A review of the clinical record for Resident 1 revealed that an alert charting note was documented by Employee 1 dated [DATE], at 10:47 AM.</p> <p>The logbook was reviewed and the entry for Resident 1 was not in the logbook. The Nursing Home Administrator (NHA) informed the surveyor that the forms are discarded after each page is completed.</p> <p>The alert charting note on [DATE], stated, daughter concerned, resident has a headache, lips dry, VS (vital signs) stable, alert charting, MD (Medical Director) aware. There was no documentation that the MD was informed of the Resident's lower-than-normal blood pressure of ,d+[DATE], decreased oral intakes, or a decline in cognition. There was no documentation regarding the family member requesting a urine sample be tested to rule out a urinary tract infection.</p> <p>Further review of Resident 1's clinical record revealed there was no alert charting or any progress notes by nursing staff on [DATE], 5, 6, or 7, 2024, prior to 11:30 AM.</p> <p>On [DATE], at approximately 11:30 AM, Resident 1 was found unresponsive in her wheelchair. Staff attempted calling her name and doing a sternal rub with no response.</p> <p>A review of Resident 1's clinical record revealed the only nursing staff documentation after being found unresponsive was, [DATE], at 11:56 AM, RN Called to assess resident that was unresponsive sitting in the wheelchair at the nurse's station. Resident was not responding to name or sternal rub. Resident was assisted to the bed, vital signs monitored. Pulse was weak and thready. Defibrillator indicated to start chest compressions. EMS called. MD notified, and order obtained to send resident to the hospital for further evaluation. RP [responsible party] notified. [DATE], at 12:03 PM, Resident was sent out to the hospital today this nurse called the family and spoke with them about residents' condition and that resident was taken to hospital by EMS. [DATE], 7:48 PM admitted to hospital with septic shock.</p> <p>There was no blood pressure recorded in the medical record during the code event or prior to transport. There was no documentation of the details of the life sustaining measures that were done. There was no documentation of what, if anything, was performed by EMS or their arrival and leave time.</p> <p>During an interview with Employee 2 (Registered Nurse) on [DATE], at 9:45 AM, Employee 2 said that she was called to Resident 1's unit and found her unresponsive. She and other staff placed the Resident into her bed. Employee 2 said that Resident 1 had a weak, thready pulse (typically considered an emergency and could be an indication of low blood pressure). Chest compressions were initiated while a code was called, and the AED (automated external defibrillator) was applied that informed the staff to continue CPR. The MD was notified and gave orders for transport to the emergency room and Emergency Medical Services (EMS) was notified.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a review of the hospital records dated [DATE], Resident 1 was diagnosed in the emergency room with septic shock due to a complicated urinary tract infection. Prior to being sent to the ICU (intensive care unit) on [DATE], at 2:36 PM, documented vital signs in the emergency room were blood pressure ,d+[DATE], temperature 97.9, heart rate 108, respirations 40, and blood sugar 76. Resident was transferred to the ICU, however, the hospital team was unable to reverse the organ failure. With family agreement, medications were discontinued and the Resident was placed on comfort measures. The Resident passed away [DATE], at 2:54 AM.</p> <p>During an interview with the NHA on [DATE], at 10:08 AM, he was not in agreement that the absence of the alert charting and further monitoring of Resident 1 rose to the level of immediate jeopardy.</p> <p>On [DATE], at 10:08 AM, the NHA was provided the Immediate Jeopardy template, and an immediate action plan was requested to ensure that residents were being assessed for and receiving adequate monitoring for changes in condition.</p> <p>On [DATE], the facility performed an audit of residents who were on alert charting for a change in condition and identified that at least one shift of monitoring/vital signs were not performed. Audits revealed Residents , d+[DATE] had a change in condition that included: Resident 2 - vomiting; Resident 3 - shortness of breath; Resident 4 -conjunctivitis (inflammation of the eye); Resident 5 - pneumonia (lung infection); Resident 6 - ill feeling and dizzy; Resident 7 - urinary tract infection with antibiotic therapy; Resident 8 - urine with blood; Resident 9 - urinary tract infection with antibiotic therapy; Resident 10 - scrotum pain; and Resident 11 - diarrhea.</p> <p>The facility was notified on [DATE], at 2:05 PM, that the action plan was accepted.</p> <p>The plan of action included: 1) An audit will be completed on all residents with reported change of conditions in the past 30 days to ensure monitoring (alert charting) was completed, after a change in condition was identified. If monitoring was not completed, a RN assessment will be completed to ensure resident is at baseline; 2) Director of Nursing (DON) or designee will provide re-education to facility licensed staff that after a resident has a change in condition, monitoring a resident with a change in condition needs to be completed. Licensed Nursing staff will be educated on how to enter alert charting process, what to monitor for, how often, how to document interventions, document detailed code interventions i.e. EMS arrival and leave times, ongoing status, and document the physician response when notified. Education is to be completed by [DATE], and any nursing licensed staff member that did not receive education will not be able to work their next scheduled shift until education is provided. During daily clinical meeting process, progress notes will be reviewed, and alert charting will be monitored for compliance, the alert charting log binders will be brought to daily clinical meeting for review of the log to ensure residents with a change in condition are added to the log for monitoring; 3) DON or designee will complete random audits of any change of condition daily for 4 weeks and then monthly for 2 months to ensure the monitoring is completed and documented. Audit findings will be reported to the monthly QAA (Quality Assessment and Assurance) meeting for review and recommendation.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On [DATE], at 1:45 PM, the audit of Residents ,d+[DATE] with a change in condition was reviewed. Staff interviews revealed the facility had re-educated staff to the revised alert charting process and utilization of the logbook for change in condition. Interviews were conducted with one RN and two Licensed Practical Nurses; all were able to verbalize their role in obtaining vital signs, the facility Change in Condition policy, the new process to follow for alert charting, proper order entry for alert charting, and documentation of all clinical information in the resident's clinical record. An interview was conducted with one nurse aide who was able to verbalize their role in obtaining vital signs and reporting vital signs to the Licensed Practical Nurse for review and data entry every shift when residents are on alert charting.</p> <p>On [DATE], at 2:05 PM, the Immediate Jeopardy was lifted.</p> <p>The facility failed to ensure care and services were provided to Resident 1 after a change in condition, failed to report all changes to the MD, and failed to continue monitoring Resident 1's status that would include vital signs every shift, resulting in continued decline, hospitalization for septic shock, and death. At the time of the survey, this failure identified 10 additional residents with at least one missed alert charting in an immediate jeopardy situation.</p> <p>201.14(a) Responsibility of licensee</p> <p>201.18(b)(1) Management</p> <p>211.12(d)(1)(2)(3)(5) Nursing services</p>		