

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 08/22/2024
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 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>48484</p> <p>Based on observations, clinical record review, policy review, and resident and staff interviews, it was determined that the facility failed to ensure that resident needs were accommodated regarding call bell accessibility for one of 34 residents reviewed (Resident 4).</p> <p>Findings include:</p> <p>Review of facility policy, titled Answering the call light, last revised September 2022, read, in part, The purpose of this procedure is to ensure timely responses to the resident's requests and needs. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.</p> <p>Review of Resident 4's clinical record revealed diagnoses that included left above the knee amputation (AKA- removing the leg from the body), muscle weakness, and seizure disorder (a condition where brain cells malfunction and send electrical signals uncontrollably)</p> <p>Observation in Resident 4's room on August 20, 2024, at 9:34 AM, revealed her call bell was out of reach, wrapped up around her left enabler bar.</p> <p>During an interview with Resident 4 on August 20, 2024, at 9:34 AM, she revealed staff wrap her call bell up like that out of reach all the time, so she won't ring her bell.</p> <p>Interview with Employee 1 (Licensed Practical Nurse) on August 20, 2024, at 9:38 AM, revealed it is possible the nurse aides wrapped her call bell around her bar after providing care because she does not have a clip for her call bell.</p> <p>Observation in Resident 4's room on August 21, 2024, at 9:31 AM, revealed her call bell was out of reach, wrapped around her left enabler bar and hanging down to the floor.</p> <p>Review of Resident 4's care plan revealed a focus area of [Resident 4] is at risk for falls due to muscle weakness, impaired mobility with left AKA, impaired balance, seizure disorder, anemia, medication side effects. Anticonvulsant therapy to treat: seizures, last revised April 11, 2024, with an intervention for call bell in reach created on November 5, 2019.</p> <p>During an interview with the Nursing Home Administrator (NHA) on August 22, 2024, at 11:33 AM, he revealed he would expect Resident 4's call bell to be in reach.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Email correspondence with the NHA on August 22, 2024, at 11:54 AM, revealed written statements from nursing to rule out deliberately placing the call bell out of reach with intent of neglect. No further information was provided.</p> <p>28 Pa code 201.29(a) - Resident Rights</p> <p>28 Pa Code 211.12(d)(1) Nursing Services</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>33879</p> <p>Based on clinical record review, state regulation, and staff interview, it was determined that the facility failed to conduct a Significant Change Minimum Data Set (MDS - standardized assessment tool utilized to identify a resident's physical, mental and psychosocial needs) for one of two residents reviewed for Hospice (Resident 23).</p> <p>Findings include:</p> <p>Review of Centers for Medicare and Medicaid Services' Resident Assessment Instrument Version 3.0 Manual (instructions for completing the resident Minimum Data Set assessment) revealed instructions in Chapter 2 that included the direction of, An [Significant Change Minimum Data Set] is required to be preformed when a terminally ill resident enrolls in hospice program .</p> <p>Review of Resident 23's clinical record revealed diagnoses that included Alzheimer's disease (irreversible, progressive degenerative disease of the brain the results in decreased contact with reality and decreased ability to perform activities of daily living) and diabetes mellitus 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 23's MDS assessments revealed Resident 23 had an annual MDS completed with an assessment reference date of December 4, 2023.</p> <p>Review of Resident 23's clinical record revealed that Resident 23 was admitted to Hospice services on July 10, 2024.</p> <p>Review of Resident 23's MDS assessments revealed the facility did not conduct a Significant Change MDS after Resident 23 was admitted to Hospice. Instead, the facility conducted an Annual MDS assessment that had an assessment reference date of July 13, 2024 (approximately 7 months after the previous Annual MDS assessment).</p> <p>During a staff interview on August 22, 2024, at approximately 11:30 AM, the Nursing Home Administrator revealed that the facility should have conducted a Significant Change MDS, not an Annual MDS for Resident 23, as a result of Resident 23 entering Hospice services.</p> <p>28 Pa Code 211.12(d)(1)(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 - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305</p> <p>Based on observation, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for four of 37 residents reviewed (Residents 17, 100, 117, and 131).</p> <p>Findings include:</p> <p>Review of Resident 17's clinical record revealed diagnoses that included diabetes mellitus (DM- a form of diabetes that is characterized by high blood sugar, insulin resistance, and relative lack of insulin) and atrial fibrillation (irregular and rapid heartbeat).</p> <p>A review of Resident 17's Quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date of June 29, 2024, revealed in Section P. Restraints and Alarms, that Resident 17 was coded to use a restraint less than daily. Resident has a BIMS (brief interview of mental status) of 15, indicating she is cognitively intact.</p> <p>During observation and interview on August 19, 2024, with Resident 17, the Resident denied any use of a restraint currently or in the past.</p> <p>A review of physician orders and care plan failed to reveal any restraint utilized for Resident 17.</p> <p>During an interview with the Nursing Home Administrator (NHA) on August 19, 2024, the NHA confirmed that Resident 17's June 29, 2024, MDS was coded in error and confirmed the Resident has no restraints.</p> <p>Review of Resident 100's clinical record revealed diagnoses that included atherosclerotic heart disease (damage or disease in the heart's major blood vessels) and psychotic delusions with disorders (a mental health disorder is a health condition in which a person can't tell what's real from what's imagined).</p> <p>Review of Resident 100's physician orders revealed orders for Risperidone (atypical antipsychotic) medication that included Risperidone 0.25 mg one tablet by mouth two times a day for behaviors, with a start date of March 20, 2024, and Risperidone 0.5 mg one tablet by mouth two times a day for anxiety related to psychotic disorder with delusions, with a start date of October 6, 2023.</p> <p>Resident 100's MDS dated [DATE], under Section N0450. Antipsychotic Medication Review- Question C. Date of last attempted GDR [gradual dose reduction] was left blank, and Question E. Date physician documented GDR as clinically contraindicated was left blank.</p> <p>During an interview with the NHA on August 21, 2024, revealed the last GDR for the antipsychotic was contraindicated by the physician on January 22, 2024, and should have been documented in the July 6, 2024, Section N0450 of the MDS.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 117's clinical record revealed diagnoses that included end stage renal disease (ESRD-condition in which a person's kidneys cease functioning on a permanent basis), dependence on renal dialysis (external filtering of the blood performed by a machine by removing the blood and replacing it), and chronic combined systolic and diastolic congestive heart failure (heart failure in which the heart cannot pump [systolic] or fill [diastolic] properly).</p> <p>Review of Resident 117's physician orders revealed an order for dialysis three days a week, with an original order date of February 3, 2023.</p> <p>Review of Resident 117's Quarterly MDS with the assessment reference date of June 7, 2024, revealed in Section O. Special Treatments, Procedures, and Programs that the Resident was not coded receiving dialysis.</p> <p>During an interview with the NHA and the Director of Nursing (DON) on August 22, 2024, at 10:01 AM, the NHA confirmed that Resident 117's MDS should have included dialysis and was coded in error. The NHA further indicated that he would expect MDS assessments to be completed accurately.</p> <p>Review of Resident 131's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), cerebral infarction (a stroke-damage to the brain from interruption of its blood supply), and depression.</p> <p>Review of Resident 131's physician orders revealed an order for aspirin enteric coated (a barrier applied to oral medication that controls the location in the digestive tract where it is absorbed) low dose delayed release 81 mg (milligrams) one tablet by mouth daily for history of stroke, dated October 30, 2023.</p> <p>Review of Resident 131's Quarterly MDS's with the assessment reference dates of February 4, 2024, and June 6, 2024, revealed in Section N. Medications that the Resident was not coded as receiving an antiplatelet medication (a medication that decreases the formation of blood clots).</p> <p>In an email communication received from the NHA on August 21, 2024, at 3:57 PM, he confirmed that the aspirin should have been coded as an antiplatelet on Resident 131's MDS's for February 4, 2024, and June 6, 2024.</p> <p>Further review of Resident 131's clinical record revealed an order for olanzapine (an antipsychotic medication used to treat mental disorders) 10 mg give in addition to olanzapine 2.5 mg at bedtime, dated May 9, 2024; and olanzapine 2.5 mg one tablet at bedtime, dated January 1, 2024.</p> <p>Review of Resident 131's order history revealed that the Resident was originally ordered olanzapine on October 30, 2023.</p> <p>Review of Resident 131's Consultant Pharmacist MRR (Medication Regimen Review) Recommendation to Prescriber dated December 24, 2023, revealed that the pharmacist had recommended that Resident 131's olanzapine be reviewed for a gradual dose reduction (GDR). Resident 131's physician had reviewed the recommendation and notated on the form that they disagreed with a dosage reduction because Resident 131 had failed a GDR recently.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 131's Quarterly MDS's with assessment reference dates of February 4, 2024; March 29, 2024; and May 7, 2024; and their Significant Change MDS with the assessment reference date of June 20, 2024; revealed that in Section N. Medications at N0450. D. Physician documented GDR as clinically contraindicated was coded No and in E. Date physician documented GDR as clinically contraindicated was, therefore, blank.</p> <p>During an interview with the NHA and DON on August 22, 2024, at 11:22 AM, the NHA confirmed that Resident 131's MDS's were coded in error and that the GDR clinically contraindicated date should have been coded. He further indicated that he would expect residents' MDS's to be coded accurately.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa. Code 211.12(c)(d)(3)(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 - Some</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>40010</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for four of 37 residents reviewed (Residents 3, 45, 88, and 131).</p> <p>Findings include:</p> <p>Review of Resident 3's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs) and hypertension (high blood pressure).</p> <p>Review Resident 3's current physician orders revealed no orders for weights.</p> <p>Review of Resident 3's care plan revealed a focus for at nutritional risk with an intervention for weights as ordered dated January 31, 2024, and an intervention for weekly weights on Monday mornings, with a revision date of August 6, 2024.</p> <p>Review of Resident 3's weight records on August 21, 2024, revealed that their last weight was documented as being obtained on August 8, 2024.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on August 22, 2024, at 11:21 AM, the NHA indicated that Resident 3's weekly weights were completed/discontinued after August 8, 2024, and confirmed that the care plan should have been revised when the change occurred.</p> <p>Review of Resident 45's clinical record revealed diagnoses that included Alzheimer's dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and difficulty walking.</p> <p>Review of Resident 45's current physician orders failed to reveal any orders for a pressure ulcer (wound of the skin caused by pressure over a bony prominence) treatment to their sacrum (the part of the spinal column that is directly connected to the pelvis) or orders for treatment of a wound infection.</p> <p>Review of Resident 45's care plan revealed a care plan focus for actual skin breakdown related to unstageable sacral/right buttock wound, with a last revised date of July 3, 2024; and a focus for infection of/at risk for infection wound/skin, with an initiated date of July 3, 2024.</p> <p>Further review of Resident 45's clinical record revealed that the pressure ulcer to their sacrum was documented as resolved on July 10, 2024, and that Resident 45 completed their course of antibiotics for a wound infection on July 8, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the NHA and DON on August 22, 2024, at 11:21 AM, the NHA confirmed Resident 45's care plan should have been revised when their wound healed and their infection resolved. He further indicated that he would expect resident care plans to be revised accordingly to accurately reflect a resident's condition.</p> <p>Review of Resident 88's clinical record revealed diagnoses of chronic obstructive pulmonary disease (COPD - a progressive disease that damages the lungs and airways, making it difficult to breathe) and chronic respiratory failure (a long-term condition that makes it difficult for the lungs to exchange oxygen and carbon dioxide in the body).</p> <p>Review of Resident 88's physician orders on August 22, 2024, revealed that there are no current orders for oxygen with humidification. Further review of Resident 88's physician orders revealed an order for Oxygen at 4 liters/minute with humidification, that was discontinued February 25, 2023.</p> <p>Review of Resident 88's care plan on August 21, 2024, revealed a care plan with a focus area of, Resident has nose bleeds, created August 8, 2021, with an intervention of humidification bottle as ordered.</p> <p>Further review of Resident 88's care plan on August 21, 2024, revealed a care plan with a focus area of, Resident has cardiac disease created May 3, 2021, with an intervention of humidification as indicated, with a revision date of August 8, 2022.</p> <p>Further review of Resident 88's care plan on August 21, 2024, revealed a care plan with a focus area of, Resident requires use of CPAP (a machine that uses mild air pressure to keep breathing airways open while you sleep), created August 8, 2021, with an intervention of oxygen per order with humidification bottle, with a revision date of August 8, 2021</p> <p>Interview with the NHA on August 22, 2024, at 9:20 AM, revealed that Resident 88's care plan should have been revised and updated when the humidification was discontinued.</p> <p>Review of Resident 131's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), cerebral infarction (a stroke-damage to the brain from interruption of its blood supply), and depression.</p> <p>Review of Resident 131's current physician orders revealed an order for Anxiety/Anxious Behaviors: (Specify: feeling nervous, continuous worrying, difficulty relaxing, restlessness, easily annoyed, irritable, fearful); Depression/Depressive Behaviors: (Specify: crying, feeling down or hopeless, sadness, despair, lack of energy, feelings of worthlessness or self-loathing, loss of interest in socializing, fixation on death or thoughts of suicide) and Insomnia/Sleepless Behaviors: (Specify: sleeplessness, difficulty falling asleep, difficulty staying asleep, restlessness, disruption in sleep pattern), all dated October 30, 2023.</p> <p>Review of Resident 131's care plan revealed failed to reveal a care plan focus for behaviors or any documentation of their specific identified behaviors.</p> <p>During an interview with the NHA and DON on August 21, 2024, at 1:13 PM, the NHA confirmed that he would expect Resident 131's specific behaviors to be identified on their care plan.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a final interview with the NHA and DON on August 22, 2024, at 11:22 AM, the NHA indicated that he would expect resident care plans to be revised accordingly to accurately reflect a resident's condition.</p> <p>42 CFR 483.21(b) Comprehensive Care Plans</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37116</p> <p>Based on observation, policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice for three of 37 residents reviewed (Residents 11, 117, and 326).</p> <p>Findings Include:</p> <p>Review of Resident 11's clinical record revealed diagnoses that included end stage renal disease (ESRD-condition in which a person's kidneys cease functioning on a permanent basis), muscle weakness, and obstructive sleep apnea (a sleep-related breathing disorder that causes repeated disruptions in breathing during sleep).</p> <p>Review of Resident 11's physician orders revealed an order for Dialysis Precautions: No blood draws/ injections/ blood pressure from right arm. Emergency kit at bedside containing appropriate equipment, with a start date of July 4, 2024.</p> <p>Review of Resident 11's clinical record revealed she has been receiving hemodialysis (a treatment to filter wastes and water from your blood when your kidneys are not working well) since her original admission to the facility on [DATE].</p> <p>Review of Resident 11's care plan revealed a focus area Renal insufficiency related to end stage renal disease, last revised on April 24, 2024, with a focus area Do not take blood pressure or blood specimens from right arm, last revised May 7, 2024.</p> <p>Review of Resident 11's blood pressure monitoring documentation between February 19, 2024, and August 19, 2024, revealed that on 78 occasions nursing staff documented that Resident 11's blood pressure was obtained in her right arm.</p> <p>Email correspondence with the Nursing Home Administrator (NHA) on August 21, 2024, at 10:19 AM, revealed in review of the documentation and the interviews with a few nurses, [Resident 11] would never let a nurse take a blood pressure in her right arm. It is probably a documentation error.</p> <p>Follow-up interview with the NHA on August 22, 2024, at 11:33 AM, revealed he would expect nursing documentation to be accurate in accordance with professional standards.</p> <p>Review of Resident 117's clinical record revealed diagnoses that included ESRD, dependence on renal dialysis (external filtering of the blood performed by a machine by removing the blood and replacing it), and chronic combined systolic and diastolic congestive heart failure (heart failure in which the heart cannot pump [systolic] or fill [diastolic] properly).</p> <p>Review of Resident 117's physician orders revealed an order for Dialysis Precautions: No blood draws, injections, or blood pressure from left arm, with an original order date of February 3, 2023.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 117's blood pressure monitoring documentation between November 27, 2023, and August 22, 2024, revealed that on 65 occasions nursing staff documented that Resident 117's blood pressure was obtained in their left arm.</p> <p>During an interview with the NHA and Director of Nursing (DON) on August 22, 2024, at 10:01 AM, the NHA indicated that he believed this to be a documentation issue as nursing staff should know not to use Resident 117's left arm for blood pressures.</p> <p>During a follow-up interview with the NHA on August 22, 2024, at 11:33 AM, the NHA revealed he would expect nursing documentation to be accurate in accordance with professional standards, especially with residents receiving dialysis.</p> <p>Review of facility policy, titled Administering Medications, revised April 2019, revealed, Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.</p> <p>Review of Resident 326's clinical record revealed diagnoses that included congestive heart failure and atrial fibrillation (heart rhythm disorder that can cause palpitations, shortness of breath, and stroke).</p> <p>Observation of Resident 326 on August 19, 2024, at 10:53 AM, revealed her lying in bed with her overbed table in front of her. A small plastic medication cup was observed on the table with what appeared to be crushed medications mixed in a soft substance. A spoon was placed in the mixture.</p> <p>During an immediate interview with Resident 326, she confirmed that the cup contained her crushed medications mixed with applesauce. She revealed that she couldn't take her medications whole, and she was having difficulties taking what was in the cup since she could still taste them.</p> <p>During an interview with Employee 2 (Licensed Practical Nurse) on August 19, 2024, at 11:19 AM, she confirmed that she had administered the aforementioned medications to Resident 326 earlier in the morning, and had seen her start taking the medications with the spoon. Employee 3 revealed that the medication cup contained amlodipine (treats high blood pressure), aspirin, Bupropion (antidepressant), Fenofibrate (lowers cholesterol), furosemide (diuretic), and Senokot (laxative).</p> <p>Review of nursing progress note dated August 19, 2024 at 11:44 AM, revealed, Resident requested to have meds left at bedside table. Resident stated that she wanted a longer amount of time to take medications. Resident was educated on the importance of taking medications as the nurse is standing there and resident was adamant that meds needed to be left at bedside. Upon re-entering the room medications were found to not be taken completely. Resident stated that she tried, she couldn't get past the taste to take them. Resident verbally confirmed that she understood the importance of taking medication and the possible outcomes of not taking them. MD [doctor] and RR [resident representative] were notified.</p> <p>Review of Resident 326's care plan and clinical record failed to reveal evidence that she was evaluated for or determined to be able to safely self-administer her medications.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the NHA on August 21, 2024, at 1:38 PM, he revealed the expectation that Resident 326's medications should not have been left at her bedside.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(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>Provide enough food/fluids to maintain a resident's health.</p> <p>46253</p> <p>Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure proper monitoring of fluid restrictions for two of eight residents reviewed for nutrition/hydration needs (Residents 3 and 117).</p> <p>Findings include:</p> <p>Review of facility policy, titled Encouraging and Restricting Fluids, with a last revised date of October 2010, indicated in section titled General Guidelines to 1. Follow specific instructions concerning fluid intake or restrictions; and in section titled Reporting to 1. Notify the supervisor if the resident refuses the procedure and 2. Report other information in accordance with facility policy and professional standards of practice.</p> <p>Review of Resident 3's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs) and hypertension (high blood pressure).</p> <p>Review of Resident 3's physician orders revealed an order for 1800 cc (cubic centimeters) fluid restriction in 24-hour period, with an original order date of January 31, 2024.</p> <p>Review of Resident 3's task documentation for fluids with meals and fluid intake from water pitcher/free fluids for the past 30 days revealed that their combined documented fluid intake on August 8, 2024, was 2280 cc; on August 10, 2024, was 2420; on August 12, 2024, was 2100 cc; on August 13, 2024, was 2400 cc; on August 14, 2024, was 1860 cc; and on August 17, 2024, was 2040 cc, therefore, exceeding their restriction of 1800 cc on those dates.</p> <p>Review of Resident 3's clinical record failed to reveal any documentation that a nursing supervisor was notified of Resident 3 exceeding their fluid restrictions for appropriate follow-up.</p> <p>Review of Resident 117's clinical record revealed diagnoses that included end stage renal disease (ESRD-condition in which a person's kidneys cease functioning on a permanent basis), dependence on renal dialysis (external filtering of the blood performed by a machine by removing the blood and replacing it), and chronic combined systolic and diastolic congestive heart failure (heart failure in which the heart cannot pump [systolic] or fill [diastolic] properly).</p> <p>Review of Resident 117's physician orders revealed an order for 1800 cc fluid restriction in 24-hour period, with an original order date of April 19, 2023.</p> <p>Review of Resident 117's task documentation for fluids with meals and fluid intake from water pitcher/free fluids for the past 30 days revealed that their combined documented fluid intakes on July 28, 2024, was 1860 cc; on August 19, 2024, was 1940; and on August 20, 2024, was 2000 cc, therefore, exceeding their restriction of 1800 cc on those dates.</p> <p>Review of Resident 117's clinical record failed to reveal any documentation that a nursing supervisor was notified of Resident 117 exceeding their fluid restrictions for appropriate follow-up.</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>During an interview with the Nursing Home Administrator (NHA) and the Director of Nursing on August 22, 2024, at 9:36 AM, the NHA indicated that staff should have adhered to Resident 3 and 117's fluid restrictions and/or followed-up as a professional standard when the restrictions were exceeded.</p> <p>201.18(b)(1) Management</p> <p>211.10(c) Resident care policies</p> <p>211.12(d)(1)(2)(5) Nursing services</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>40010</p> <p>Based on clinical record review, policy review, and staff interview, it was determined that the facility failed ensure failed to ensure effects and side effects of psychotropic medications was being monitored for three of five residents reviewed (Resident 67, 100, and 131).</p> <p>Findings include:</p> <p>Review of facility policy, Antipsychotic Medication Use, revised July 2022, revealed, The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications and Nursing staff shall monitor for and report . side effects and adverse consequences of antipsychotic medications to the attending physician.</p> <p>Review of Resident 67's clinical record revealed diagnoses that included psychotic disorder (a condition that causes people to lose touch with reality) and depression (major loss of interest in pleasurable activities, characterized by change in sleep patterns, appetite and or daily routine).</p> <p>Review of Resident 67's physician's orders dated August 20, 2024, revealed a current order for Seroquel (antianxiety/psychotropic medication) 25 mg to be given twice daily, that was ordered on September 18, 2023.</p> <p>Review of Resident 67's clinical record on August 22, 2024, failed to reveal any monitoring for the use of this antipsychotic medication.</p> <p>Review of Resident 67's care plan on August 22, 2024, failed to reveal any care plan for the use of this antipsychotic medication.</p> <p>Interview with the Nursing Home Administrator (NHA) on August 22, 2024, at 11:32 AM, revealed that the expectation is that the facility would monitor the use of antipsychotic medications.</p> <p>Review of Resident 100's clinical record revealed diagnoses that included atherosclerotic heart disease (damage or disease in the heart's major blood vessels) and psychotic delusions with disorders (a mental health disorder is a health condition in which a person can't tell what's real from what's imagined).</p> <p>Review of Resident 100's physician orders revealed orders for Risperidone (atypical antipsychotic) medication that included Risperidone 0.25 mg one tablet by mouth two times a day for behaviors, with a start date of March 20, 2024, and Risperidone 0.5 mg one tablet by mouth two times a day for anxiety related to psychotic disorder with delusions, with a start date of October 6, 2023.</p> <p>Further review revealed physician orders were added on August 21, 2024, that stated, Side Effect Tracking- Antipsychotics- observation and documentation of potential side effects: blurred vision, dry mouth, drowsiness, muscle spasm or tremors, weight gain, tardive dyskinesia every shift. If side effect observed - please document in progress notes.</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>During an interview with the NHA on August 22, 2024, at 11:00 AM, the NHA confirmed that Resident 100's physician orders should have included monitoring for side effects when the Risperidone was initiated.</p> <p>Review of Resident 131's clinical record revealed diagnoses that included late onset Alzheimer's dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), cerebral infarction (a stroke-damage to the brain from interruption of its blood supply), and depression.</p> <p>Review of Resident 131's physician orders revealed a current order for olanzapine (an antipsychotic medication used to treat mental disorders) 10 mg give in addition to olanzapine 2.5 mg at bedtime, dated May 9, 2024; and olanzapine 2.5 mg one tablet at bedtime, dated January 1, 2024.</p> <p>Review of Resident 131's order history revealed that the Resident was originally ordered olanzapine on October 30, 2023.</p> <p>Review of Resident 131's clinical record on August 21, 2024, failed to reveal any monitoring for the use of this antipsychotic medication.</p> <p>During an interview with the NHA and the Director of Nursing on August 22, 2024, at 11:22 AM, the NHA confirmed that Resident 131 did not have side effect monitoring in place, and he indicated that the monitoring of antipsychotic medications should have been implemented when the medication was originally ordered.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(2)(5) Nursing services</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>48484</p> <p>Based on observations, review of select facility documentation, and staff interviews, it was determined that the facility failed to utilize equipment in accordance with professional standards for food service safety in the main kitchen.</p> <p>Findings include:</p> <p>Observation of the dish machine on August 19, 2024, at 9:50 AM, revealed the wash cycle temperature was reading 132 degrees Fahrenheit (degrees F- unit of measure), below the minimum standard for safety of 150 F.</p> <p>Return observation of the dish machine during lunchtime on August 19, 2024, at 1:11 PM, revealed the wash cycle temperature was reading 125 F and the dishes that came out of the cycle still had food particles on them. Employee 5 (Dietary Employee) took the rack of dishes and returned them to the front of the dish machine to be rewashed.</p> <p>Interview with Employee 4 (Dietary Manager) on August 19, 2024, at 1:26 PM, revealed when the dish machine is not functioning properly, the process is to move to paper products or use the three-compartment sink to wash dishes, and that he does have a work order in for the dish machine.</p> <p>Interview with the Nursing Home Administrator (NHA) on August 19, 2024, at 1:41 PM, revealed they are calling the vendor, switching to paper products for meal service, and doing an event report.</p> <p>Follow-up interview with the NHA on August 20, 2024, at 1:04 PM, revealed the dish machine needed a replacement part and the facility has ordered it to be shipped overnight.</p> <p>Review of December 2023 dish machine temperature log revealed the recorded final rinse cycle temperatures were below the minimum safe temperature on December 1 and 11-31 at breakfast; December 10, 20, and 27-31 at lunch; and December 3, 7, 10-13, 16, 17, and 19 at dinner.</p> <p>Review of the January 2024 dish machine temperature log revealed the recorded wash cycle temperatures were below the minimum safe temperature on January 29 and 30 at breakfast; and January 26 and 28 at dinner.</p> <p>Further review of the January 2024 dish machine temperature log revealed the recorded final rinse cycle temperatures were below the minimum safe temperature on January 1-24 on all shifts; January 25, 27, 29 and 30 at breakfast; January 25 at lunch; and January 26-29, and 31 at dinner; no wash or rinse temperatures were recorded at breakfast or lunch on January 31.</p> <p>Review of the February 2024 dish machine temperature log revealed the recorded wash cycle temperatures were below the minimum safe temperature on February 22-24 at breakfast; and February 25 at dinner.</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>Further review of the February 2024 dish machine temperature log revealed the recorded final rinse cycle temperatures were below the minimum safe temperature on February 19-29 on all shifts; no wash or rinse temperatures were recorded at lunch or dinner on February 17.</p> <p>Review of the March 2024 dish machine temperature log revealed the recorded wash cycle temperatures were below the minimum safe temperature on March 2, 11-16, 18-21, and 25 at breakfast; and March 2, 11, 12, 20, and 21 at lunch.</p> <p>Further review of the March 2024 dish machine temperature log revealed the recorded final rinse cycle temperatures were below the minimum safe temperature on March 1-6, 10-23, and 25 at breakfast; 2-6, 9-23, 25 and 30 at lunch; and March 1, 3, 12-21, and 24-31 at dinner.</p> <p>Review of the April 2024 dish machine temperature log revealed the recorded final rinse cycle temperatures were below the minimum safe temperature on April 6, 14, 17, 25, 29 and 30 at breakfast; April 18-21, 23-25, and 29 at lunch; and April 3, 4, 6, 8, 10-13, 15, 17, 20-22, and 26-30 at dinner.</p> <p>Review of the May 2024 dish machine temperature log revealed the recorded final rinse cycle temperatures were below the minimum safe temperature on March 1 at breakfast and lunch; and on all shifts May 2-31.</p> <p>Review of the June 2024 dish machine temperature log revealed the recorded wash cycle temperatures were below the minimum safe temperature on June 1, 3, 4, 6, and 8 at dinner.</p> <p>Further review of the June 2024 dish machine temperature log revealed the recorded final rinse cycle temperatures were below the minimum safe temperature on June 1-24, and 27-30 at breakfast; June 3-28, and 30 at lunch; and June 1-4, 6-30 at dinner.</p> <p>Review of the July 2024 dish machine temperature log revealed the recorded wash cycle temperatures were below the minimum safe temperature on July 26 and 27 at dinner.</p> <p>Further review of the July 2024 dish machine temperature log revealed the recorded final rinse cycle temperatures were below the minimum safe temperature on July 1-31 at breakfast and lunch; and July 3, 5-28, and 31 at dinner.</p> <p>Review of the August 2024 dish machine temperature log revealed the recorded final rinse cycle temperatures were below the minimum safe temperature on August 1-7, and 10-18 at breakfast, August 1-7, 10-13, and 15-18 at lunch; and August 1, 3, 11, and 13-17 at dinner.</p> <p>During an interview with the NHA on August 21, 2024, at 1:41 PM, the surveyor discussed the possibility that staff is sometimes recording the wrong temperature gauge in the final rinse section. He revealed the expectation for kitchen equipment to be utilized and monitored in accordance with professional standards.</p> <p>28 Pa. Code 211.6(f) Dietary services</p> <p>28 Pa. Code 201.18(b)(3)(e)(2.1) 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 - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>33305</p> <p>Based on staff interviews and facility policy review, it was determined the facility failed to maintain a data collection system of surveillance for three of 12 months reviewed (October 2023; November 2023; and December 2023).</p> <p>Findings include:</p> <p>Review of the facility policy, titled Surveillance for Infections, last reviewed January 19, 2024, revealed the facility will maintain a monthly line list of residents with infections for trending and outbreak potential to include the following data; identifying information i.e., name, age, room number, unit, and attending physician; admitted , date of onset, symptoms if known, and date of positive diagnostic test; site; pathogen and invasive procedures or risk factors (i.e., surgery, indwelling tubes, fractured hip, malnutrition, altered mental status).</p> <p>During an interview with the Employee 3 (Infection Control Preventionist [ICP]) on August 20, 2024, at approximately 11:00 AM, the ICP revealed the facility was unable to find any data collection system of surveillance from the previous full health survey through June of 2024. The ICP added that she was recently hired for the position and was only able to provide the July 2024 data. The data did not show all of the information on residents with infections per their policy requirements.</p> <p>On August 21, 2024, the facility was able to find and present a data collection system of surveillance for January 2024 through June 2024 that was retrieved from the corporate office.</p> <p>On August 22, 2024, the facility's monthly data collection system of surveillance for October 2023 through December 2023 was unable to be provided by the facility.</p> <p>During an interview with the Nursing Home Administrator (NHA) on July 22, 2024, at 1:00 PM, the NHA was unable to provide the October 2023, November 2023, and December 2023 infection control data per facility policy, but added that a discussion at QAPI (Quality Assessment Performance Improvement) about the infections for those months should suffice.</p> <p>28 Pa Code 201.14(a)(c)Responsibility of licensee</p> <p>28 Pa Code 211.1(a)(c)Reportable diseases</p>		