| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 395644 | A. Building<br>B. Wing | 10/18/2024 |

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| Mid-Valley Health Care Center | 81 Sturges Road<br>Peckville, PA 18452 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277<br><br>Based on review of clinical records, select facility policy, and staff interview it was determined the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure that licensed nurses accurately administered prescribed medication to one of 14 sampled residents (Resident 18).<br><br>Findings include:<br><br>According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to carry out nursing care actions that promote, maintain, and restore the well-being of individuals.<br><br>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records.<br><br>Review of the facility policy titled General Dose Preparation and Medication Administration last reviewed by the facility on January 8, 2024, revealed that prior to the administration of medication, facility staff should verify, each time a medication is administered, that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, and for the correct resident. Staff are to confirm that the MAR (Medication Administration Record) reflects the most recent medication order.<br><br>A review of the clinical record revealed Resident 18 was admitted to the facility on [DATE], with diagnoses to include symbolic dysfunction (a type of social communication and language disorder), chronic atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), arthritis, and protein-calorie malnutrition (a condition caused by not getting enough calories or the right amount of protein and nutrients needed for health).<br><br>(continued on next page) |

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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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility document Consultation Report dated September 4, 2024, revealed the facility's consultant pharmacist conduced a Medication Record Review and reported that Resident 18 had received Lorazepam 0.5 mg PO (by mouth) BID (two times a day) since June 2024 for anxiety. The pharmacist recommended a gradual dose reduction (GDR) of Lorazepam to 0.25 mg PO BID (by mouth two times a day).<br><br>A review of the physician's response to the pharmacist recommendation dated September 6, 2024, revealed the physician agreed with the recommendation for the GDR with the following modification: decrease Lorazepam to 0.25 mg for the AM dose and maintain 0.5 mg for the PM dose.<br><br>A review of the physician's order dated June 7, 2024, revealed an order for Lorazepam tablet; administer 0. 25 mg PO (by mouth) daily in the AM for anxiety related to end stage disease process. Once a day at 8:00 AM.<br><br>A review of the physician's order dated June 7, 2024, revealed an order for Lorazepam tablet; administer 0.5 mg PO daily in the PM for anxiety related to end stage disease process. Once a day at 8:00 PM.<br><br>Review of a nurses note dated September 24, 2024, at 3:39 PM identified that Resident 18 continued to receive the 0.5 mg dose of Lorazepam in the AM instead of the 0.25 mg dose as ordered on September 7, 2024. The nurses note indicated there was no change in the narcotic sheet (controlled medication utilization record- a detailed record that tracks the receipt, distribution, and administration of controlled substances), and no change noted on the medication card (sealed blister pack that contains a specific medication). The note continued to state that there was a failure to match the physician order in the eMAR (electronic Medication Administration Record) to the medication card. The pharmacy received the script for the 0.25 mg on time but did not send the 0.25 mg medication card because of insurance reasons. Nursing called the pharmacy to send the medication. The Director of Nursing, Nursing Home Administrator, Physician, and Resident Representative were notified.<br><br>Review of the facility document Event Report dated September 24, 2024 at 2:01 PM revealed the facility administered 0.5 mg of Ativan (lorazepam) instead of 0.25 mg of Ativan for the morning dose. The Event Report classified the event as a Medication Error Review with the date of the error identified on September 24, 2024. The error had occurred since September 6, 2024, and was identified by the LPN (licensed practical nurse) working the medication cart. The description of the error revealed that Ativan was reduced from 0.5 mg in the morning to 0.25 mg. It was written in the physician orders and not on the medication card or narcotic record. It was administered as whole tablets to the resident (0.5 mg). The pharmacy was called to send the 0.25 mg medication card. The pharmacy said they received the script but did not send the medication card because of insurance reasons. The type of error was identified as 'incorrect dose, incorrect label, and medication not available. There were no adverse drug reactions identified for the resident. Medication competencies were completed for nursing staff and medication cart audits were completed.<br><br>A review of the Controlled Medication Utilization Records for Lorazepam 0.5 mg tablet revealed that from September 8, 2024, through September 23, 2024, Resident 18 received 16 doses of Lorazepam 0.5 mg for the AM dose instead of the 0.25 mg dose as ordered by the physician on September 7, 2024.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on October 17, 2024, at 1:00 PM the Director of Nursing (DON) confirmed that nursing staff failed to follow acceptable standards of nursing practice during medication administration resulting in a medication error and failed to administer the resident's Lorazepam as prescribed.<br><br>28 Pa. Code 211.9 (a)(1)(d) Pharmacy services<br><br>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services<br><br>28 Pa. Code 211.5 (f)(i) Medical records |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460<br><br>Based on a review of clinical records and staff and resident interviews it was determined the facility failed to develop and implement care and services, consistent with professional standards of practice, to prevent pressure ulcer development for one resident (Resident 89) and failed to assess and monitor facility acquired pressure injuries for two residents out of 14 sampled (Residents 18, and 8).<br><br>Findings included:<br><br>According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address the areas of risk.<br><br>The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i. e. support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair.<br><br>A review of the clinical record revealed that Resident 89 was most recently admitted to the facility on [DATE], with diagnoses that included chronic foot drop (difficulty lifting the front part of the foot, which might cause foot to drag on the ground when walking) of the right lower extremity, cellulitis (a bacterial infection that affects the skin and underlying tissues) of the left lower limb, and after care for a fractured left tibia and fibula (leg).<br><br>A review of hospital discharge orders dated September 6, 2024, revealed Orthopedic Instructions which instructed, strict elevation, compressive ace wrap, continue antibiotics, and keep upcoming appointment with Orthopedic surgeon.<br><br>A review of Resident 89's admission physician orders dated September 6, 2024, indicated an appointment was scheduled for September 10, 2024, with the Orthopedic surgeon. There was no evidence that a compression ace wrap and/or strict elevation of the resident's surgically repaired left lower extremity was implemented as instructed in hospital discharge orders.<br><br>A review of facility Admission/Readmission observation dated September 6, 2024, indicated that Resident 89 had 2+ pitting edema (a grade given to swelling caused by fluid buildup in the body, where a slight indentation remains in the skin after pressure is applied and disappears within 15 seconds) of the left lower extremity. The left lower extremity had redness and discoloration (red and inflamed), weight bearing limitations, toe touch weight bearing of the left extremity, the resident complained of pain of the left lower extremity, alterations in skin integrity included surgical incisions of the left lower extremity and a pressure injury to the thoracic spine.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Further review of the Admission/Readmission Braden scale (a tool used to predict the risk of pressure ulcers) indicated the resident scored a 14 which indicated a moderate risk for development of pressure ulcers.<br><br>A review of the facility's Wound Management Detail Report dated September 6, 2024, identified the following skin concerns upon Resident 89's return from the hospital:<br><br>1. Pressure ulcer to mid-upper back on the spine which measured 1cm x 1cm, and treatment was initiated.<br><br>2. Surgical incision to left knee over patellar (kneecap) region, no measurements and/or observation performed, site covered with surgical dressing.<br><br>3. Surgical incision to left shin median (inner) side which measured 2.5cm x 1cm, edges well approximated, and bruising noted. A dry sterile dressing was applied after incision was cleansed with normal saline solution.<br><br>4. Surgical incision to left shin with blood blisters present which measured 1.5cm x 0.1cm with edges well approximated, and five staples present, surrounding skin was warm. A dry sterile dressing was applied after observation.<br><br>5. Surgical incision to the left ankle just above the ankle medial side which measured 2cm x 1cm with four staples present, and surrounding skin was warm. No treatment initiated according to report.<br><br>6. Surgical incision to left shin lateral (outer) lower shin above the ankle which measured 1cm x 0.1cm with two staples present, surrounding skin was bruised, and a dry sterile dressing was applied after observation.<br><br>An MDS Assessment (Minimum Data Set assessment - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated September 10, 2024, revealed the resident was cognitively intact with a BIMS score of 15 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact), required substantial/maximal assistance from staff for toileting, showers, putting on/taking off footwear, and lower body dressing and was at risk for pressure ulcer development.<br><br>A review of Resident 89's care plan failed to identify a focus area related to the resident's risk for development of pressure ulcers, therefore, there was no evidence that interventions were implemented to prevent the development of pressure ulcers.<br><br>A review of nursing documentation dated September 6, 2024, indicated the nurse practitioner ordered to have an ultrasound doppler of the resident's left leg to rule out DVT (deep vein thrombosis formation of a blood clot in a deep vein).<br><br>A review of nursing documentation dated September 10, 2024, revealed that a doppler study and ultrasound of Resident 89's left lower extremity was completed and was positive for a DVT. Further review of the documentation revealed the attending physician ordered changes to the resident's medication regimen and blood work due to the positive doppler results.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of nursing documentation completed from September 6, 2024, through September 19, 2024, revealed that Resident 89 continued to be treated with antibiotic therapy for cellulitis of the left lower extremity, and had persistent mild edema.<br><br>A review of documentation completed by Physical Therapy on September 19, 2024, indicated that Resident 89 had complained of pain in the left heel, nursing identified a DTI (deep tissue injury, is an injury underlying tissue below the skin's surface that results from prolonged pressure in an area of the body. Similar to a pressure sore, a deep tissue injury restricts blood flow in the tissue causing the tissue to die.) on left heel. Resident instructed in positioning in bed and pressure relieving techniques.<br><br>Documentation dated September 19, 2024, at 11:56 p.m. indicated that Resident 89 had acquired a DTI (deep tissue injury) of the left heel which measured 2cm x 2cm x 0cm. According to the documentation, immediate keep safe intervention was implemented which included a treatment to the area, to offload the weight with pillows under her calf by wearing heel boots.<br><br>A review of a facility Skin/Skin Integrity event report dated September 19, 2024, revealed that Resident 89 had acquired an unstageable DTI (deep tissue injury) to the left heel which measured 2cm x 2cm, was dark purple in color, and skin was intact. Interventions implemented at time of discovery were heel protectors to be worn at all times except while in therapy, pressure reduction device to bed and/or chair, and therapy consult.<br><br>Review of a witness statement dated September 19, 2024, completed by the ADON (assistant director of nursing)/Wound care nurse revealed the ADON was informed of the area on Resident 89's heel by the Occupational Therapist and the therapist advised off-loading the heel with pillows under the calf and to use heel bows (heel protectors).<br><br>Review of witness statement dated September 19, 2024, completed by Employee 5, a Nurse Aide (NA), indicated that Employee 5 was not aware the resident had a pressure sore on her heel due to the presence of a dressing on her heel.<br><br>A review of the facility's Wound Management Report dated September 19, 2024, indicated that Resident 89 had a pressure injury to the left heel which measured 2cm x 2cm, and treatment orders for Santyl to the wound were initiated as ordered by the podiatrist.<br><br>A review a wound care consultant documentation dated September 23, 2024, at 1:19 p.m. indicated that Resident 89's left heel DTI had evolved to an unstageable pressure ulcer (pressure ulcers covered with slough or eschar are by definition unstageable) which measured 3cm x 3cm x 0.1cm, 30% slough (moist dead tissue), and 70% eschar (dark, dry, firm dead tissue). Recommendations included to cleanse the ulcer with normal saline, apply betadine on area of eschar, apply Santyl (ointment used to remove damaged tissue from skin) to areas of slough to base of the wound, secure with bordered gauze, change daily and as needed, and float heels while in bed with use of Prevalon boots (device used to help prevent heel pressure ulcers by keeping the heel off of a surface like a bed).<br><br>Review of clinical record revealed that on September 24, 2024, Resident 89 was transferred to the hospital for evaluation of worsening swelling of the left lower extremity, inability for resident to bend her knee, and increased tenderness of the leg. Resident 89 was admitted to the hospital with diagnosis of a bacterial skin infection.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | When reviewed at the time of the survey ending October 18, 2024, there was no documented evidence prior to the development of the unstageable left heel pressure ulcer, that nursing staff had implemented interventions to prevent the development of the ulcer despite the resident's numerous risk factors.<br><br>The facility failed to demonstrate the timely and consistent implementation of specific measures designed to prevent pressure sores on the resident's heels.<br><br>Interview with the Director of Nursing on October 18, 2024, at approximately 2:10 PM, confirmed that preventative interventions were not timely and consistently implemented to prevent the development of the left heel pressure ulcer for a resident at risk for skin breakdown.<br><br>A review of the clinical record revealed Resident 18 was admitted to the facility on [DATE], with diagnoses to include symbolic dysfunction (a type of social communication and language disorder), chronic atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), arthritis, and protein-calorie malnutrition (a condition caused by not getting enough calories or the right amount of protein and nutrients needed for health).<br><br>A review of the quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment completed at specific times to identify resident care needs) dated May 3, 2024, revealed that Resident 18 was at risk for a pressure ulcer development, had pressure reducing devices for her bed and chair, and was not on a turning/repositioning program. Further review revealed the resident was on hospice services (end of life care) and was dependent on staff for all activities of daily living (turning/repositioning, bed mobility, transfers, eating, bathing, toileting).<br><br>A review of the resident's care plan, initiated May 4, 2024, revealed the facility identified the resident was at risk for skin breakdown related to decreased mobility and weakness. Interventions included to apply barrier cream to bilateral buttocks, keep skin clean and dry, monitor for skin breakdown, elevate heels off mattress, provide skin prep to bilateral heels, provide a pressure reducing mattress, and provide a pressure reducing cushion on the wheelchair.<br><br>Review of a nurses note dated June 21, 2024, at 10:38 AM revealed the nurse was called to Resident 18's room during morning care by the certified nursing assistant who noticed an open area to her coccyx. The area measured 1.5 cm x 0.2 cm x 0.1 cm. The area was cleansed with normal saline solution and a hydrogel (wound dressing), and a dry dressing was applied. The resident was returned to bed after her meal and repositioned from side to side. The resident did not complain of pain. Call placed to physician, responsible party, and Hospice to make aware.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the Wound Consultation documentation dated June 26, 2024, at 11:48 AM indicated that Resident 18 had a Stage 3 pressure wound (a serious wound caused by pressure in which the wound has worn through all skin layers, exposing the fat) to the left inner buttock that measured 2 cm x 0.5 cm x 0.2 cm, exudate was moderate serosanguineous (wound drainage that contains both blood and a clear yellow liquid known as blood serum). Recommendations included: cleanse the wound with normal saline, apply Hydrogel to wound base and apply barrier cream to surrounding skin, the resident is to be out of bed for meals only, continue with pressure redistributing cushion to wheelchair, turning/repositioning precautions per protocol, ensure setting on low air-loss mattress (a mattress designed to distribute the resident's body weight over a broad surface area and help prevent skin breakdown) was maintained at appropriate levels, and continue ongoing interventions for incontinence management as resident is incontinent of urine and stool.<br><br>A review of facility documentation Point of Care History (POC- general care nursing tasks completed for the resident) from May 1, 2024, through June 20, 2024, failed to identify that preventative measures were developed and implemented in order to prevent the development of a pressure ulcer.<br><br>At the time of the survey ending October 18, 2024, the facility was unable to provide documented evidence that staff provided a turn and repositioning schedule and proper and timely incontinence care to prevent a pressure ulcer.<br><br>Interview with the Director of Nursing on October 17, 2024, at 2:00 PM confirmed that there was no evidence the facility had implemented adequate interventions to prevent the development of Resident 18's pressure ulcer.<br><br>A review of Resident 8's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included dementia (is a term used to describe a group of symptoms affecting memory, thinking and social abilities) with behavior disturbances, diabetes, congestive heart failure (CHF is a long-term condition that happens when the heart can't pump blood well enough to give the body a normal supply resulting in blood and fluids to collect in the lungs and legs over time and require medication), and anxiety (characterized by excessive, persistent and uncontrollable worry and fear about everyday situations).<br><br>A clinical record review of Resident 8's admission/readmission observation assessment that was completed by Employee 1, a licensed practical nurse (LPN), dated May 27, 2024, at 1:27 PM, revealed the resident had no skin alterations, no abrasions, no bruises, no burns, no dermatitis, no skin grafts, no surgical incisions, or pressure injuries. Employee 1 commented that Resident 8 had a fluid filled blister (a small bubble on the skin filled with fluid caused by rubbing surfaces together) to the right heel.<br><br>Additionally, the resident's Braden Scale Score (is a standardized, evidence-based assessment tool commonly used in health care to assess and document a client's risk for developing pressure injuries) was a thirteen 13 which indicated moderate risk of developing pressure injuries due to the risk factors related to very moist skin, bedfast (confined to bed), very limited mobility, friction and shearing (frequently slides down in bed or chair, requiring frequent repositioning with maximum assist). Interventions for skin ulcer/injury treatments such as a turning and repositioning program, pressure reducing device for chair, ointments/medications other than to feet, and applications of dressings to feet (with or without topical medication) was coded by Employee 1 as none of the above were provided.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of the resident's pressure ulcer healing report completed by Employee 2, a Registered Nurse (RN), dated May 28, 2024, at 7:24 AM, indicated that Resident 8 had a serous (clear to yellow fluid) filled blister to the right heel (no measurements or description noted).<br><br>Further review of Resident 8's clinical record revealed a functional abilities assessment completed by Employee 3, a RN, and dated May 28, 2024, at 7:38 PM, revealed the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for bed mobility and was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or requires the assistance of 2 or more helpers is required for the resident to complete the activity) for all activities of daily living such as toileting, hygiene/care needs, transfers, sit to standing, and all other ADLs (activities of daily living).<br><br>On May 28, 2024, at 12:25 PM, the Assistant Director of Nursing (ADON) noted an observation of the blister measurements as 7.0 centimeters (cm) in length and 5.5 cm in width and commented the resident's podiatrist would follow up with the blister and does not want the facility wound care team to treat the resident.<br><br>However, on May 29, 2024, at 9:02 AM, the Director of Nursing (DON) modified the documentation of the wound on the resident's wound history report and noted the right heel was a stage 2 pressure ulcer (is a shallow open wound, abrasions, or blisters due to partial thickness loss of the dermis) instead of a blister.<br><br>Resident 8's clinical recorded revealed that the consulted podiatrist was at the facility on May 30, 2024, at 11:21 AM, and evaluated the right heel blister.<br><br>A review of the podiatrist's consult dated May 30, 2024, and faxed to the facility on [DATE], at 11:04 AM, revealed that Resident 8 had a diagnosis of peripheral vascular disease (PVD - is the buildup of plaque inside the artery wall. Plaque reduces the amount of blood flow to the limbs) and noted to continue skin prep and dry dressing to the right heel and air pillow heel protectors (cushion to elevate heels to prevent pressure) for bedtime.<br><br>A review of a wound observation completed by Employee 4, an RN, on May 31, 2024, at 10:09 PM, revealed that Resident 8's intact blister to the right heel ruptured with a small amount serous drainage, no odor noted, and a red beefy moist base with blister shell cleared to one side of wound but still intact. No signs or symptoms of infection. Attending MD, responsible party (RP) and podiatry aware of changes.<br><br>A review of a wound observation completed by the ADON on June 3, 2024, at 11:19 AM, revealed that Resident 8's right heel measurements were 7.0 cm in length by 8.0 cm in width and 0.2 cm in depth with a heavy amount of serous (clear) exudate and moderate odor from the discharge and noted that the area was at a stage 3 pressure ulcer (have gone through the second layer of skin into the fat tissue with symptoms that include a crater appearance, may have a foul odor, and may show signs of infection such as red edges, pus, odor, heat, and/or drainage with the tissue in or around the sore appearing black indicating dead tissue) with slough present and commented that a sterile border foam dressing was applied after cleaning with betadine.<br><br>(continued on next page) |

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| | 395644 | A. Building<br>B. Wing | 10/18/2024 |

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| Mid-Valley Health Care Center | 81 Sturges Road<br>Peckville, PA 18452 |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The facility could not provide documented evidence the attending physician, consulted podiatrist, or RP were notified of Resident 8's right heel deterioration from a stage 2 to stage 3 pressure ulcer.<br><br>Additionally, there was no documented evidence that the area was evaluated to determine if alternate treatments or interventions were indicated to promote healing and prevent infection.<br><br>Further review of a wound observation completed by the ADON on June 7, 2024, at 3:33 PM, revealed the resident's right heel wound exhibited further deterioration as evidence by changes in the appearance of the exudate from serous (clear) to serosanguineous (pale red to pink, thin and watery) with faint odor and covered with twenty percent necrotic (dead) tissue and irregular wound edges/margins. The area was measured at 7.0 cm in length by 8.0 cm in width with 0.2 cm depth.<br><br>A review of Resident 8's clinical record revealed that on June 7, 2024, at 3:28 PM, the ADON completed a progress note that a message was left at the podiatrist's office to follow up with the wound as the area has black eschar in the wound bed.<br><br>A review of the resident Medication Administration Summary report dated May 27, 2024, through June 10, 2024, revealed no documented evidence the facility timely developed and implemented pressure ulcer prevention measures that deterred Resident 8's right heel blister from deteriorating.<br><br>Further review of the resident's record revealed that Employee 2 completed a progress note dated June 10, 2023, at 2:52 PM (four days later), revealed that the podiatrist was in to examine resident's right heel with new orders noted to change order to thin Duoderm (a flexible waterproof dressing used to cover burns and reduce infection) to the area and change every other day.<br><br>Resident 8's clinical record failed to reveal documented evidence the resident's right heel blister was timely and thoroughly assessed by a registered nurse to develop and implement effective preventative measures to deter the area from evolving (worsening) from a blister to a stage 3 pressure ulcer.<br><br>Additionally, Resident 8's clinical record failed to reveal the facility timely notified the resident's attending physician, consulted physician (podiatrist), of deterioration to the resident's right heel and failed to document applied treatments/interventions.<br><br>An interview with the DON on October 18, 2024, at 2:00 PM, confirmed that upon admission to the facility Resident 8 failed to be timely and thoroughly assessed by an RN to ensure that effective preventative pressure relieving measures were timely implemented to deter the right heel blister from deteriorating to a Stage 3 pressure ulcer.<br><br>Additionally, the DON confirmed the facility failed to timely notify the resident's attending physician or consultant physician (podiatrist), of Resident 8's deterioration to the resident's right heel and ensure that proper treatments/interventions were applied and documented timely and accurately in the resident's clinical record.<br><br>28 Pa. Code 211.5(f) Medical records<br><br>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services. |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460<br><br>Based on a review of clinical records and staff interview, it was determined the facility failed to develop and implement an individualized person-centered plan to render trauma informed care to a resident with a diagnosis of Post-Traumatic Stress Disorder for one out of 14 residents reviewed (Resident 2).<br><br>Findings include:<br><br>A review of Resident 2s clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included Post Traumatic Stress Disorder (PTSD a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event).<br><br>The resident's current care plan, in effect at the time of review on October 18, 2024, did not identify the resident's PTSD symptoms or triggers related to this diagnosis and resident specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization.<br><br>The facility failed to develop and implement an individualized person-centered plan to address, this resident's diagnosis of PTSD according to standards of practice to promote the resident's emotional well-being and safety.<br><br>Interview with the Director of Nursing on October 18, 2024, at 10:00 AM confirmed the facility was unable to demonstrate the facility provided culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident.<br><br>28 Pa Code 211.12 (d)(3)(5) Nursing services. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944<br><br>Based on a review of pharmacy documentation, clinical records and staff interviews it was determined the facility failed to implement procedures to assure timely acquiring and administration of medications to one of 14 sampled residents (Resident 18).<br><br>Findings include:<br><br>A review of the clinical record revealed Resident 18 was admitted to the facility on [DATE], with diagnoses to include symbolic dysfunction (a type of social communication and language disorder), chronic atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), arthritis, and protein-calorie malnutrition (a condition caused by not getting enough calories or the right amount of protein and nutrients needed for health).<br><br>A review of the physician's response to the pharmacist recommendation dated September 6, 2024, revealed the physician agreed to decrease Lorazepam (an antianxiety medication) to 0.25 mg for the AM dose and maintain 0.5 mg for the PM dose.<br><br>A review of the physician's order dated June 7, 2024, revealed an order for Lorazepam tablet, administer 0. 25 mg PO (by mouth) daily in the AM once per day at 8:00 AM, for anxiety related to end stage disease process.<br><br>A review of the physician's order dated June 7, 2024, revealed an order for Lorazepam tablet, administer 0.5 mg PO daily in the PM once per day at 8:00 PM, for anxiety related to end stage disease process.<br><br>A review of a nurses note dated September 24, 2024, at 3:39 PM, identified that Resident 18 continued to receive the 0.5 mg dose of Lorazepam in the AM instead of the 0.25 mg dose as ordered on September 7, 2024, and noted that the pharmacy received the script for the 0.25 mg on time but did not send the 0.25 mg medication card because of insurance reasons. Additionally, it was noted that nursing called the pharmacy to send the medication and that the Director of Nursing, Nursing Home Administrator, Physician, and Resident Representative were notified.<br><br>A review of the Controlled Medication Utilization Records for Lorazepam 0.5 mg tablet revealed that from September 8, 2024, through September 23, 2024, Resident 18 received sixteen doses of Lorazepam 0.5 mg for the AM dose instead of the 0.25 mg dose as ordered by the physician on September 7, 2024.<br><br>A review of a facility document Event Report dated September 24, 2024, at 2:01 PM, revealed the facility administered 0.5 mg of Ativan (lorazepam) instead of 0.25 mg of Ativan for the morning dose and was classified by the facility as a medication error. The pharmacy indicated that they received the script but did not send the medication card because of insurance reasons.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | There was no documented evidence that the pharmacy communicated to the facility that the pharmacy received the new physician order on September 7, 2024, for the 0.25 mg Lorazepam and no documented evidence that the pharmacy communicated to the facility when the 0.25 mg of Lorazepam would be sent to the facility.<br><br>Additionally, the pharmacy failed to assure timely allocation/delivery to the facility of a physician prescribed medication, Lorazepam.<br><br>An interview with the Nursing Home Administrator on October 18, 2024, at 2:30 PM, revealed the facility failed to assure timely acquiring and administration of medications to provide medications as ordered to meet the needs of residents.<br><br>Refer F684<br><br>28 Pa. Code 211.9 (a)(1)(d) Pharmacy services<br><br>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services<br><br>28 Pa. Code 211.5 (f)(i) Medical records |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944<br><br>Based on clinical record and staff interview, it was determined the facility failed to ensure the presence of documented evidence of clinical necessity for administration of an antibiotic drug for one resident out of 14 sampled (Resident 8).<br><br>Findings included:<br><br>A review of Resident 8's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included dementia (is a term used to describe a group of symptoms affecting memory, thinking and social abilities) with behavior disturbances, and CHF (congestive heart failure is a long-term condition that happens when the heart can't pump blood well enough to give the body a normal supply resulting in blood and fluids to collect in the lungs and legs (swelling) over time and require medication) and anxiety (characterized by excessive, persistent and uncontrollable worry and fear about everyday situations).<br><br>A review of Resident 8's clinical record completed by Employee 2, a Registered Nurse (RN), dated September 9, 2024, at 2:25 PM, revealed that the contracted psychiatric CRNP was notified of ongoing behaviors such as constant calling out, crying, rambling speech, nervousness, wringing of hands, requesting that staff sit with her. New orders were received to obtain a UA (urinalysis) and C & S (culture and sensitivity) and attending physician and responsible party aware.<br><br>A review of a physician order dated September 18, 2024, at 8:12 AM, revealed an order for Macrobid 100 milligrams (mg) give one capsule orally twice per day as prophylaxis (preventative) for UTI (urinary tract infection).<br><br>A review of a progress note completed by the resident's attending physician dated October 1, 2024, at 8:02 PM, revealed that Resident 8 appeared very anxious with constant, nonstop, nonsensical rambling and was yelling at times and appeared in distress. There was no improvement with treatment of a urinary tract infection and had upper respiratory congestion and tested positive for COVID-19 and received prescribed antiviral medication to manage and currently stable from a COVID standpoint.<br><br>Physical assessment completed and resident Afebrile (without a fever), blood pressure was 116/62, pulse 72, lungs CTA (clear to auscultation: a term used during physical examinations to indicate normal lung sounds), and edema stable.<br><br>She had increased behaviors and urinalysis showed pyuria (increased urination) with clumps and was given Macrobid with daily prophylaxis after treatment.<br><br>A review of Resident 8's Medication Administration Record (MAR) dated September 2024 revealed that Resident 8 received 25 doses of the antibiotic.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) on October 18, 2024, at 10:18 AM, it was reported that as a part of the facility's infection prevention program, to deter physician's from prescribing unnecessary/inappropriate antibiotic therapy, the nursing staff complete an assessment of the residents condition (SBAR) to determine if the McGreer's Criteria (a standard infection criteria tool) was met to determine if the resident's symptoms and laboratory data meet the criteria for the prescription of antibiotic therapy.<br><br>Additionally, the ADON/IP also reported that she reported that Resident 8 did not have repeated urinalysis and culture and sensitivity or an SBAR completed due to the resident's attending physician insisting that the resident complete another round of antibiotic (Macrobid) due to the resident's continued escalating behaviors despite no results to justify prescribing continued use of an antibiotic.<br><br>The facility failed to ensure that Resident 8's medication regimen was free from the use of unnecessary antibiotic (Macrobid) and did not meet the criteria for the use of the antibiotic for prophylaxis.<br><br>During an interview with the Director of Nursing on October 18, 2024, at 11:00 AM, it was confirmed that the facility failed to ensure that Resident 8's medication regimen was free from an unnecessary medication.<br><br>28 Pa. Code 211.2 (3) Medical Director<br><br>28 Pa. Code 211.9 (k) Pharmacy Services<br><br>28 Pa. Code 211.12 (d)(1)(3) Nursing Services<br><br>28 Pa. Code 211.5 (f) (iv)(ix)Medical records |