

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Birchwood Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 395 Middle Road Nanticoke, PA 18634	

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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on review of clinical records and facility-initiated transfer notices and a staff interview, it was determined that the facility failed to provide written notices of facility-initiated hospital transfers of residents, prepared in a language and manner that could be easily understood to three out of 19 residents reviewed (Resident 32, 56, and 87).</p> <p>Findings include:</p> <p>Regulatory requirements indicate that before a facility transfers or discharges a resident, the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.</p> <p>A review of the clinical record revealed that Resident 32 required to be transferred to the hospital on March 25, 2024, and was readmitted to the facility on [DATE].</p> <p>A review of the facility provided Facility Initiated Notice of Transfer or Discharge revealed that the resident required an immediate transfer/discharge to an acute care facility on March 25, 2024, because the resident's urgent medical needs cannot be met in the facility due to (reason for transfer/discharge in terms understood by the resident and resident representative) hematemeses (vomiting blood). The facility failed to use language that could be easily understood by the resident or resident representative.</p> <p>A review of the clinical record revealed that Resident 56 was transferred to the hospital on February 25, 2024, and returned to the facility that same day.</p> <p>A review of the facility provided Facility Initiated Notice of Transfer or Discharge revealed that the resident required an immediate transfer/discharge to an acute care facility on February 25, 2024, because the resident's urgent medical needs cannot be met in the facility due to (reason for transfer/discharge in terms understood by the resident and resident representative) eval and treat.</p> <p>A review of the clinical record revealed that Resident 87 was transferred to the hospital on March 5, 2024 and later returned to the facility.</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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility provided Facility Initiated Notice of Transfer or Discharge revealed that the resident required an immediate transfer/discharge to an acute care facility on March 5, 2024, because the resident's urgent medical needs cannot be met in the facility due to (reason for transfer/discharge in terms understood by the resident and resident representative) abnormal vitals.</p> <p>Interview with the Nursing Home Administrator on June 7, 2024, at approximately 1:30 PM confirmed that the facility failed to provide transfer information in a language that could be understood by both the resident and/or resident representative.</p> <p>28 Pa. Code 201.29 (a)(c.3)(2) Resident rights</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944</p> <p>Based on a review of clinical records, observations and staff and resident interviews it was determined that the facility failed to provide planned care and services, consistent with professional standards of practice to treat pressure sores and prevent worsening for one resident out of 19 sampled (Resident 32).</p> <p>Findings included:</p> <p>A review of Resident 32's clinical record revealed that the resident was initially admitted to the facility on [DATE], with diagnoses to have included a cerebral infarction [occurs when the blood supply to part of the brain is blocked or reduced, which prevents brain tissue from getting oxygen and nutrients that result in brain cells dying], vascular dementia [is a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain], 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 that results in blood and fluids building-up in the lungs and legs over time], and chronic pressure ulcer to the right outer foot.</p> <p>A review of Resident 32's plan of care for skin impairment initiated on July 24, 2023, indicated that he was at risk for impaired skin integrity related hemiplegia with right sided weakness, incontinence, decreased mobility, use of a molded ankle-foot orthosis [(MAFO) is an orthotic device used to control foot and ankle alignment and compensate for muscle weakness that should be worn based on a wearing schedule to prevent skin irritation and breakdown] splint to right lower extremity. According to the resident's care plan on September 16, 2024, the resident had a calloused blister to his right foot. Planned interventions included skin checks every shift to the right foot related to use of a MAFO splint, administer medication(s) and apply treatment(s) as per physician/nurse practitioner/physician assistant, skin checks every seven days, and if resident refuses interventions, encourage compliance to minimize risk for skin impairments.</p> <p>A review of a podiatry consultation in Resident 32's clinical record dated February 12, 2024, revealed that the resident was seen due to chronic pain in his right foot and indicated that the pain was related to a pressure ulcer. The podiatrist's recommendations included to cleanse the area with saline and apply Betadine and cover with a dry sterile dressing BID (twice per day) and to hold the use/wearing of the resident's MAFO for two weeks.</p> <p>A review of the resident's Treatment Administration Record [(TAR, or eTAR for electronic versions), commonly referred to as a treatment chart, is the report that serves as a legal record of physician ordered treatments applied at a facility by a health care professional. The TAR is a part of a patient's permanent record on their medical chart. The health care professional signs off on the record at the time that the treatment or device is administered] dated February 2024, revealed that the treatment to cleanse the area (right outer foot) with saline and apply Betadine and cover with a dry sterile dressing BID (twice per day) was not applied as prescribed by the podiatrist from February 13, 2024, through March 7, 2024.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At the time of the survey ending June 7, 2024, the facility was unable to provide documented evidence that staff applied the treatment as prescribed for 24 days, with the resident missing 48 treatments.</p> <p>During an interview with the facility's wound care nurse on June 6, 2024, at 12:29 p.m., the nurse stated that the facility's licensed nursing staff erroneously entered the treatment application schedule for the right outer foot area into the eTAR and confirmed that the resident missed 24 days of treatments. The wound care nurse reported that when staff noticed that the treatments were not recorded in the eTAR that the order was reinitiated.</p> <p>Further review of the clinical record revealed that the resident was admitted to the hospital on March 25, 2024, due to a change in condition, with coffee ground emesis [is vomit that looks like coffee grounds and is dark brown or black in color with a lumpy texture, which the appearance comes from old and coagulated blood in your gastrointestinal tract] and was readmitted to the facility on [DATE].</p> <p>A review of Resident 32's readmission wound assessment that was completed by a registered nurse (RN), dated March 28, 2024, at 2:15 p.m., revealed that the resident had a blood blister the right outer foot that measured 4.0 cm in length by 2.0 cm in width and no depth and orders to consult wound care specialists.</p> <p>A review of the resident's TAR dated from March 28, 2024, to April 15, 2024, failed to reveal that treatments were applied to Resident 32's right outer foot blister.</p> <p>The wound care specialist's initial wound evaluation dated April 15, 2024, revealed that Resident 32 had a stage 3 pressure ulcer [involve full-thickness skin loss potentially extending into the subcutaneous tissue layer] to the right outer foot that measured 3.0 cm in length by 3.0 cm in width by 0.20 cm in depth with no epithelial tissue, 25-49% granulation, 50-74% slough, with a moderate amount of serosanguinous exudate, and no odor present.</p> <p>Further interview with the facility's wound care nurse on June 6, 2024, at 2:00 p.m., confirmed that there was no documented evidence that a treatment was applied to the resident's blistered area to the right foot upon readmission and that there was no documented evidence of weekly wound tracking completed by the facility until the wound care specialist assessed the area at a stage 3 pressure sore.</p> <p>28 Pa. Code: 211.12 (c)(d)(1)(3)(5) Nursing Services</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</p> <p>Based on clinical record and select policy review, and staff interview it was determined that the facility failed to provide care and services designed to prevent potential complications with enteral tube feedings for one resident receiving an enteral feeding out of 19 residents sampled (Resident 56).</p> <p>Findings include:</p> <p>Review of a facility policy entitled Enteral Feeding provided by the facility on June 6, 2024, indicated that the facility will provide adequate nutritional support through enteral nutrition as ordered. According to the policy, staff caring for resident with feeding tubes are trained on how to recognize and report complications associated with the insertion and/or use of a feeding tube, such as clogging of the tube.</p> <p>Review of Resident 56's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included dysphagia (difficulty swallowing), epilepsy (neurological condition involving the brain that makes people more susceptible to having recurrent unprovoked seizures), and quadriplegia (paralysis of the arms and legs).</p> <p>Resident 56 required a PEG tube [Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube (PEG tube) is passed into the patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate [for example, because of dysphagia] for enteral feeding [enteral nutrition generally refers to any method of feeding that uses the gastrointestinal (GI) tract to deliver part or all of a person's caloric requirements].</p> <p>Review of Resident 56's plan of care, initiated on September 4, 2023, revealed a focus area related to the need for tube feeding/ potential for complications of feeding tube use related to dysphagia. Interventions planned were to administer medication and/or vitamin supplements as ordered, the tube feeding formula, hydration, and flushes as order. The care plan failed to identify the type and size of the PEG tube the resident required.</p> <p>The resident had a physician order, dated February 16, 2024, for continuous tube feeding of Jevity 1.5 at 55 ml (milliliters) an hour, up at 4 PM and down at 12 PM until total volume of 1100 mL have been infused. An additional order dated February 15, 2024, was noted for an 83 mL water flush every 2 hours for a total of 996 mL every 24 hours (excludes medication flushes), and an order dated July 24, 2023, to verify proper tube feed placement before medication administration, feeding and flushes, four times a day. The resident's physician orders failed to specify the type and size of PEG tube the resident required, and the amount of water flushes required before and after administration of medication.</p> <p>Review of clinical record revealed documentation dated February 27, 2024, at 12:04 PM that the physician was notified that the resident's feeding tube was clogged. New orders were received to send the resident out of facility for feeding tube replacement.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident's clinical documentation revealed that on February 27, 2024, the resident returned to the facility without having her feeding tube replaced. According to the documentation, the resident arrived to the appointment late and the office was closed when she arrived. The appointment needed to be rescheduled.</p> <p>Nursing documentation dated March 1, 2024, at 7:53 AM indicated that the resident left the facility to have her feeding tube replaced, 3 days from initial date the tube was noted to be blocked.</p> <p>Review of Medication Administration Records dated February 2024 and March 2024 revealed that all ordered medications, feedings, and water flushes were administered via the feeding tube, despite documentation the nursing documentation on February 27, 2024, indicating that the resident's feeding tube was blocked and required replacement on February 27, 2024, through March 1, 2024.</p> <p>Interview with Employee 2, licensed practical nurse on June 6, 2024, at 9:45 AM indicated that Resident 56's feeding tube was only sluggish and not fully blocked. According to Employee 2, medications, water flushes, and enteral feedings were able to be administered as ordered while awaiting for the feeding tube to be changed.</p> <p>Interview with the Assistant Director of Nursing and Employee 2 on June 6, 2024, at 9:50 AM confirmed that there was no documentation that the resident's feeding tube continued to be functioning despite being blocked. There was no evidence that the physician or the resident's representative were made aware that there was a delay in having the resident's feeding tube replaced due to late arrival for the resident's appointment on February 27, 2024.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on June 7, 2024, at approximately 2:00 PM, confirmed that the facility failed to provide care and services designed to prevent potential complications associated with tube feedings and that the physician and RP were notified of changes accordingly.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services.</p> <p>28 Pa. Code 211.10 (c)(d) Resident care policies</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929</p> <p>Based on a review of clinical records and staff interview, it was determined that the attending physician failed to act upon pharmacist identified irregularities in the medication regimen of one of 19 residents sampled (Resident 46).</p> <p>Findings include:</p> <p>A review of the clinical record revealed Resident 46 was admitted to the facility on [DATE], and had diagnoses that included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), and bipolar disorder.</p> <p>A review of February 2024 monthly pharmacy reviews revealed that the consultant pharmacist noted that the resident was prescribed as needed Ativan .5 mg for anxiety. Noting that per CMS guidelines all PRN psychotropic agents must be limited to a 14-day duration. This resident currently has an active PRN order for Lorazepam that requires change to meet these regulations.</p> <p>The facility failed to provide written documentation of the attending physician's response to the drug irregularity and there was no documentation that the resident's physician acknowledged this identified pharmacy report.</p> <p>The Director of Nursing on June 7, 2024, at approximately 10:00 AM and confirmed that the attending physician had not acted upon the pharmacy irregularity.</p> <p>28 Pa. Code 211.9 (k) Pharmacy services.</p> <p>28 Pa Code 211.5 (f) Medical records</p> <p>28 Pa. Code 211.2 (d)(7) Medical director</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>43944</p> <p>Based on observation, a review of temperature logs and staff interview it was determined that the facility failed to store drugs and pharmacy supplies under proper temperatures (2nd Floor Medication Room) and adhere to expiration/use by dates in one medication storage rooms out of two medication storage rooms.</p> <p>Findings include:</p> <p>Review of facility provided document entitled Temperature Log for Refrigerator indicated that medications and vaccines requiring refrigeration storage should be stored at a temperature range of 35 degrees Fahrenheit to 46 degrees Fahrenheit.</p> <p>An observation of the 2nd Floor Medication Storage Room sink on June 6, 2024, at 8:52 a.m., revealed that there was a white putty-like substance smeared inside.</p> <p>Observation of the 2nd Floor Medication Storage Room refrigerator revealed that the initial temperature reading on June 6, 2024, at 8:56 a.m., was at 28 degrees Fahrenheit and was below the acceptable temperature range 36 - 46 degrees Fahrenheit for medication storage. The freezer compartment had an accumulation of ice crystals covering the surface.</p> <p>Observations of the 2nd Floor Medication Stock Medication cabinet, contained over the counter (OTC) medications and supplements, on June 6, 2024, at 11:55 a.m., revealed that the following medications were present in the cabinet and outdated:</p> <p>Glucosamine and Chondroitin Triple Strength [nutritional supplement that may manage chronic joint pain and arthritis] 120 tablets had a manufacture's expiration date of February 2024</p> <p>Ferrous Gluconate [iron supplement] 240 milligrams (mg) 100 tablets that had a manufacturer's best by date of October 2022</p> <p>Sodium Bicarbonate [an antacid] 650 mg 1000 tablets that had a manufacture's expiration date of May 2024</p> <p>Further observations on June 6, 2024, at 12:06 p.m., revealed that the 2nd Floor Medication Room refrigerator temperature was 28-degrees Fahrenheit and remained below the acceptable temperature range and the sink still had a white putty-like substance inside.</p> <p>An interview with the Director of Nursing (DON) on June 7, 2024, at 11:38 a.m., confirmed that the 2nd Floor Medication Storage Room refrigerator was within proper temperatures, the med room area was not kept in a sanitary manner, and medications were kept beyond the expiration/use by date.</p> <p>28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services</p> <p>(continued on next page)</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(3)(5) Nursing services