

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395678	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2025
NAME OF PROVIDER OR SUPPLIER  Williamsport Home, The		STREET ADDRESS, CITY, STATE, ZIP CODE  1900 Ravine Road Williamsport, PA 17701	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 29512</p> <p>Based on observation and staff and resident interview, it was determined that the facility failed to provide adequate housekeeping and maintenance services to ensure a clean, safe, and orderly environment on 3 of six nursing units (300 400, and 500 Nursing Units, Residents 14, 3, 81, and 84) and at the facility's main entrance.</p> <p>Findings include:</p> <p>Observation of the 300 Hall Nursing Unit on the following dates and times revealed the following:</p> <p>On February 25, 2025, at 1:31 PM there was a strong odor of urine in Resident 14's room.</p> <p>On February 26, 2025, at 11:27 AM and February 27, 2025, at 1:00 PM and there was an odor of urine in Resident 14's room.</p> <p>Observation of the main entrance to the facility on [DATE], at 1:02 PM and February 27, 2025, at 8:33 AM and 12:48 PM, revealed the following:</p> <p>One medical face mask was discarded on the ground and two others discarded in the landscape adjacent to the main entrance of the facility.</p> <p>A used tissue discarded in the planter next to the main entrance.</p> <p>An overflowing garbage can.</p> <p>Multiple cigarette butts discarded on the ground and landscape at the base of the steps leading to the parking lot in front of the main entrance.</p> <p>The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on February 27, 2025, at 2:45 PM.</p> <p>Observation of the 400 Hall Nursing Unit on the following dates and times revealed the following:</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On February 26, 2025, at 10:45 AM observation of Resident 81's room revealed that the paint was peeling on the wall next to the bed, the wall next to the closet was all marred, and the frame around the closet was all marred.</p> <p>Observation of the 500 Hall Nursing Unit on the following dates and times revealed the following:</p> <p>Observation of Resident 3's room on February 26, 2025, at 9:22 AM revealed that the frame around her closet was all marred.</p> <p>Observation of Resident 84's room on February 26, 2025, at 10:59 AM revealed that there were rolled towels on her windowsill tight up against the windows. Concurrent interview with Resident 84 revealed that the towels were there to keep the cold air out.</p> <p>The Nursing Home Administrator and the Director of Nursing were made aware of the above noted concerns for Residents 3, 81, and 84, during a meeting on February 27, 2025, at 3:00 PM.</p> <p>28 Pa. Code 201.18(b)(3) Management</p> <p>28 Pa. Code 207.2(a) Administrator's responsibility</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>29512</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to assess and implement interventions to maintain a resident's continence status for one of four residents reviewed (Resident 9).</p> <p>Findings include:</p> <p>The MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) Resident Assessment Indicators (RAI) 3.0 Manual, Section H indicated that each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible.</p> <p>Clinical record review for Resident 9 revealed that since July 3, 2024, Resident 1 had a physician's order to transfer and ambulate with use of a gait belt, a rolling walker, and one staff assistance. The facility completed an annual MDS assessment on January 24, 2025. The facility identified that Resident 9 was moderately impaired, with a BIMS (Brief Interview for Mental Status, assessment that scores a resident's response to memory questions; 8-12 indicates moderately impaired) of 10, was frequently incontinent of bowel and bladder, and not on a toileting plan.</p> <p>Review of Resident 9's task interventions (an action intended to improve the resident's health and comfort) revealed that the facility placed them on a check and change toileting program since April 16, 2024, and a restorative ambulation program since October 17, 2024. Further review of January 8, 2025, through January 14, 2025, (the annual MDS lookback/review period) revealed that Resident 9 was incontinent of bowel 3 times, continent of bowel five times, incontinent of urine 10 times, continent of urine 13 times, and actively participated in the restorative ambulation program during six of the seven day and evening shifts reviewed. Resident 9 ambulated between five and 160 feet during this time period.</p> <p>Review of Resident 9's nursing documentation revealed the following:</p> <p>On January 24, 2025, at 2:52 PM staff documented that Resident 9 remained frequently incontinent of bowel and bladder. Staff report Resident 9 does have continent episodes at times and will assist them to the toilet per her request, however, was usually always incontinent even when the resident voided. The facility will continue a check and change toileting program to ensure the resident was kept clean, dry, and odor free. Resident 9 was on a resident nursing program for ambulation and was able to meet, at times exceed, her ambulation distance goal with no changes at that time.</p> <p>On January 28, 2025, at 10:47 PM staff documented that Resident 9 was alert, verbal, and able to make needs known. They ambulate with a rolling walker, a gait belt, and assist of one staff member and needed one staff to assist with activities of daily living, bed mobility, and toileting. Staff noted that Resident 9 had mixed incontinence of bladder and was continent of bowel.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documentation that staff identified Resident 9's potential to increase and/or maintain bowel and/or bladder continence, completed a bowel and bladder tracker, and assessed Resident 9 for either a prompted or scheduled toileting program after the January 2025, annual MDS assessment.</p> <p>The above information was reviewed with the Director of Nursing on February 7, 2025, at 1:23 PM.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>38839</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to store oxygen and respiratory care equipment consistent with professional standards of practice for two of two residents reviewed for respiratory care (Residents 28 and 74).</p> <p>Findings include:</p> <p>Observation of Resident 28 on February 25, 2025, at 2:43 PM revealed a nebulizer machine (a small machine that turns liquid medicine into a mist that can be easily inhaled) sitting on the resident's stand beside her bed. A mouthpiece connected to the tubing coming from the machine was observed hanging down in front of the stand uncovered. Resident 28 indicated they received nebulizer treatments two or three times a day.</p> <p>An observation of Resident 28 on February 26, 2025, at 9:25 AM revealed the nebulizer machine again sitting on the resident's stand beside her bed with the mouthpiece hanging down in front of the stand uncovered.</p> <p>Clinical record review for Resident 28 revealed the resident was ordered Ipratropium-Albuterol Solution (a liquid) to inhale by mouth using a nebulizer every four hours as needed for shortness of breath on January 30, 2025.</p> <p>A review of Resident 28's medication administration record for February 2025, revealed the resident had not been administered the solution via the nebulizer since it was last administered on February 22, 2025.</p> <p>The above information was reviewed with the Nursing Home Administrator and Director of Nursing on February 26, 2025, at 3:35 PM</p> <p>Observation of Resident 74's room on February 25, 2025, at 11:45 AM revealed he was in bed with supplemental oxygen on. His oxygen source was a free-standing oxygen cylinder tank. The tank was not in a stand or secured.</p> <p>The Nursing Home Administrator was made aware of Resident 74's oxygen tank and the safety concerns at 12:05 PM on February 25, 2025.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>36798</p> <p>Based on clinical record review and resident and staff interview, it was determined that the facility failed to ensure that pain management was provided that was consistent with professional standards of practice for one of one resident reviewed (Resident 84).</p> <p>Findings include:</p> <p>Interview with Resident 84 on February 26, 2025, at 11:24 AM she indicated that she has pain and that it is not controlled with the medication that they give her. She said her pain is in her legs and that it is worse when they move her. She indicated that she usually would ask staff for her pain medication and if it is time they will give it to her.</p> <p>A physician's progress note dated December 17, 2024, at 6:08 PM revealed that Resident 84 was seen by orthopedics related to her left leg contracture and they reported that her extremity is bone on bone and that she is not a surgical candidate. They recommended palliative care and pain management. The physician discontinued her Tramadol (a medication used to treat moderate to severe pain) and increased her dose of Oxycodone (a medication used to treat moderate to severe pain).</p> <p>A palliative care progress noted dated December 24, 2024, at 10:29 AM revealed that Resident 84 presented with pain in the left lower extremity and her right ankle. The note also indicated that Resident 84 reports pain and nursing reports that she complains of severe pain in the left lower extremity and right ankle pain. Nursing reported that Resident 84 currently takes her ordered as needed Oxycodone medication and it is effective. The note also indicated that on assessment Resident 84 states she has mild pain without movement and severe pain with movement and care.</p> <p>Clinical record review for Resident 84 revealed current physician orders for Tylenol (a medication used to control mild pain) 325 milligrams (mg) give two tablets every four hours as needed for a pain level of one to three, Oxycodone HCl oral tablets 5 mg give one tablet every four hours as needed for a pain level of four to six, and Oxycodone HCl oral tablets 5 mg give two tablets by mouth every four hours as needed for a pain level of seven to 10.</p> <p>Review of Resident 84's medication administration record (MAR) for December 2024, to February 26, 2025, revealed that she received Tylenol 325 mg two tablets for a pain level of 1-3 on December 5, 18, 28, 29, 2024, and January 4, 10, 12-14, 21, and 26, 2025.</p> <p>Review of Resident 84's MAR for December 2024, to February 26, 2025, revealed that she received Oxycodone 5 mg tablets one tablet every four hours as needed for a 4-6 pain level at least once daily December 19, 21-22, and 24-31, 2024, January 1-12, 14-20, and 23-31, 2025, and February 1-26, 2025.</p> <p>Review of Resident 84's MAR for December 2024, to February 26, 2025, revealed that she received Oxycodone 5 mg tablets two tablet every four hours as needed for 7-10 pain level at least once daily December 20, 23-26, and 28-31, 2024, January 2, 3, 5, 8-12, 15, 17, 21-23, 25-27, 29-31, 2025, and February 4-6, 8, 10, 13-16, 21, 23, and 26, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Director of Nursing on February 28, 2025, at 10:01 AM confirmed the above noted findings related to Resident 84's pain.</p> <p>The facility failed to ensure that Resident 84's received pain management that was consistent with professional standards of practice.</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>29512</p> <p>Based on observation, clinical record review, and staff and resident interview, it was determined that the facility failed to assess for the risk of side rail entrapment for 6 of 11 residents reviewed for accident hazards (Residents 3, 9, 12, 38, 71, and 262), and review the risk and benefits of side rail utilization with the resident or resident representative, and receive consent for the use of side rails for 5 of 11 residents reviewed for accident hazards (Residents 3, 9, 12, 59, 71).</p> <p>Findings include:</p> <p>Observation of Resident 12's room on February 26, 2025, at 11:23 AM revealed that there were bilateral grab bars observed on the bed.</p> <p>Clinical record review for Resident 12 revealed that the facility completed an enabler bar assessment, review of potential risks, and consent on November 29, 2023. The facility completed an enabler bar entrapment evaluation on December 27, 2023, which indicated that they passed for potential entrapment for zones one (within the rail), two (between the bottom of the rail and top of compressed mattress), three (between the edge of the mattress and inside of the rail, and four (between the top of the compressed mattress and the bottom of the rail at the end of the rail). There was no documentation that indicated the facility assessed zone six (between the end of the rail and the side edge of the head or foot board) for potential entrapment.</p> <p>On May 1, 2024, Resident 12 moved to another room and a different bed. There was no documentation that indicated the facility assessed Resident 12's new bed and grab bars for the potential risk of entrapment.</p> <p>Observation of Resident 9's room on February 25, 2025, at 1:50 PM and February 26, 2025, at 11:24 AM revealed that there were bilateral grab bars observed on the bed.</p> <p>Clinical record review for Resident 9 revealed that the facility completed an enabler bar evaluation on May 2, 2024, when she moved to a new room and a different bed that indicated they passed for potential entrapment in zones one through four. There was no documentation that indicated the facility assessed zone six (between the end of the rail and the side edge of the head or foot board) for potential entrapment.</p> <p>Observation of Resident 71's room on February 25, 2025, at 8:57 AM, 12:58 PM and 1:46 PM revealed that there were bilateral grab bars observed on the bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review for Resident 71 revealed that that was a current physician's order dated August 16, 2024, for the resident to utilize grab bars as enablers to promote independent bed mobility. Since August 16, 2024, Resident 71 had moved to a different room and a different bed three times. There was no documentation that Resident 71's bilateral side rails were assessed with each room move to ensure the grab rails were appropriate, that the resident's ability to utilize them was evaluated, or the risk of entrapment was evaluated. There was no documentation that the facility received consent from Resident 71 or their responsible party to utilize enabler bars or that the facility provided education to Resident 71 and their responsible party regarding the potential risks of utilizing enabler bars.</p> <p>The above information was reviewed during an interview with the Nursing Home Director and the Director of Nursing on February 27, 2025, at 2:45 PM.</p> <p>Observation of Resident 3 on February 25, 2025, at 1:30 PM revealed she was in a chair beside her bed. Observation revealed that her bed had bilateral grab bars on it. Concurrent interview with Resident 3 revealed that when she is in bed, she utilizes the grab bars to turn and to get in and out of bed.</p> <p>Clinical record review revealed that Resident 3 had a physician's order dated October 8, 2024, for bilateral grab bars to use as an enabler to promote independent bed mobility.</p> <p>Further clinical record review revealed a grab bar evaluation completed on October 3, 2024, that indicated the grab bars were indicated and serve as an enabler to promote independence for Resident 3.</p> <p>The evaluation form revealed that there was no risk for entrapment in zones one, two, three, and four as per measurements obtained by staff. The evaluation form did not include an assessment or review of zone six, which could potentially pose a risk for entrapment between the end of the grab bar device and the side of the headboard.</p> <p>The Director of Nursing was made aware of the above noted concerns related to Resident 3 on February 27, 2025, at 3:08 PM.</p> <p>Review of the census for Resident 59 revealed the resident changed rooms on October 30, 2024.</p> <p>Observation of Resident 59 on February 26, 2025, at 9:36 AM revealed the resident was in bed and had bilateral enabler bars attached to the bed.</p> <p>The Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated February 15, 2025, revealed that facility staff assessed Resident 59 as having a BIMS (Brief Interview for Mental Status) of 99, which indicated the resident was unable to complete the assessment interview.</p> <p>Current physician orders for Resident 59 dated February 12, 2025, revealed an order for grab bars to assist with independent mobility.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Plan of Care note dated February 13, 2025, at 3:41 PM revealed documentation that indicated Resident 59 recently had grab bars applied to his bed, and staff reported the grab bars had improved bed mobility.</p> <p>Documentation for Resident 59 titled, Grab Bar/Side Rail Evaluation, noted the resident was assessed as not capable. However, staff further assessed that the grab bars were indicated and serve as an enabler to promote independence.</p> <p>Further review of the documentation, Grab Bar/Side Rail Evaluation, for Resident 59 revealed consent was obtained verbally from the responsible party and dated February 27, 2025 (after the grab bars were applied to the bed).</p> <p>An interview with the Director of Nursing on February 27, 2025, at 12:18 PM confirmed that the risk assessment/evaluation and consent was not completed until after the grab bars were placed on Resident 59's current bed.</p> <p>An observation of Resident 262 on February 25, 2025, at 2:01 PM revealed the resident was in bed with bilateral enabler bars on the bed.</p> <p>Clinical record review for Resident 262 revealed a side rail evaluation dated February 7, 2025, assessing the need for the enabler bars to promote independence and consent by the resident for the enabler bars.</p> <p>Review of an entrapment zone measurement sheet for Resident 262 revealed the form was not completed until February 25, 2025, and indicated the risk of entrapment was assessed for zones 1 through zone four, but did not assess for the risk of entrapment in zone 6 as noted above.</p> <p>An observation of Resident 38 on February 26, 2025, at 10:30 AM revealed the resident was in bed with bilateral enabler bars on the bed.</p> <p>Review of an entrapment zone measurement sheet for Resident 38 indicated the risk of entrapment was assessed for zone 1 through zone four, but did not assess for the risk of entrapment in zone 6 as noted above.</p> <p>The concerns regarding Residents 262 and 38 not being assessed for risk in zone six were reviewed with the Nursing Home Administrator and Director of Nursing on February 27, 2025, at 3:10 PM.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>44738</p> <p>Based on review of select facility policies, clinical record review, and staff interview, it was determined that the facility failed to ensure a timely physician response to consultant pharmacist recommendations for three of five residents reviewed (Residents 21, 57, and 64).</p> <p>Findings include:</p> <p>The facility policy Monthly Medication Regimen Review, last reviewed on February 11, 2025, revealed that if an identified irregularity requires urgent action, the pharmacist will immediately report the irregularity to the Director of Nursing or designee and the attending physician by phone.</p> <p>Review of a medication regimen review for Resident 57 dated September 26, 2024, revealed a Consultation Report, which noted the pharmacist made a recommendation of a gradual dose reduction (GDR) for the resident's Duloxetine (a medication used to treat depression, anxiety, and sometimes pain).</p> <p>Further review of this documentation for Resident 57 revealed that the physician had responded to the recommendation by declining it, signing, and dating the document on November 15, 2024. The documentation was also dated and signed by the Director of Nursing on November 20, 2024.</p> <p>Review of a medication regimen review for Resident 64 dated August 29, 2024, revealed a Consultation Report, which noted the pharmacist made a recommendation to reduce the resident's omeprazole (a medication used to treat certain stomach problems) to 20 milligrams (mg) twice a day and administer 30 to 60 minutes before food.</p> <p>Further review of this documentation for Resident 64 revealed that the physician had responded to the recommendation by accepting it, signing, and dating the document on October 25, 2024. The documentation was also dated and signed by the Director of Nursing on October 25, 2024.</p> <p>Review of a medication regimen review for Resident 64 dated October 24, 2024, revealed a Consultation Report, which noted the pharmacist made a recommendation of a GDR for the resident's Olanzapine (an antipsychotic medication).</p> <p>Further review of this documentation for Resident 64 revealed that the physician had responded to the recommendation by accepting it, signing, and dating the document on November 27, 2024. The documentation was also dated and signed by the Director of Nursing on December 2, 2024.</p> <p>The facility failed to address in their policy and procedure, for monthly medication regimen review, an appropriate time frame for physician response to a pharmacist recommendation and ensure a timely physician's response to monthly recommendations made by the pharmacist.</p> <p>The above information for Residents 57 and 64 were reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on February 27, 2025, at 2:45 PM.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Williamsport Home, The		STREET ADDRESS, CITY, STATE, ZIP CODE  1900 Ravine Road Williamsport, PA 17701	
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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a medication regimen review for Resident 21 dated September 26, 2024, revealed a Consultation Report, which noted the pharmacist made a recommendation to decrease Resident 21's Omeprazole (a medication used to treat gastroesophageal reflux disease- a digestive disorder in which the stomach acid irritates the food pipe lining) dose to 20 milligrams 30-60 minutes before food.</p> <p>Further review of this documentation for Resident 21 revealed that the physician had responded to the recommendation by accepting it, signing, and dating the document on November 5, 2024, one month and 10 days after the recommendation was made.</p> <p>The Director of Nursing was made aware of the above noted concerns related to the untimely response by the physician for Resident 21's consultant pharmacy recommendation in a meeting on February 27, 2025, at 3:10 PM.</p> <p>483.45(c) Drug Regimen Review</p> <p>Previously cited 2/2/24</p> <p>28 Pa. Code 211.9 (k) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38839</p> <p>Based on clinical record review and resident and staff interview, it was determined that the facility failed to administer medication to a resident based on professional standards of practice resulting in the potential for a significant medication error for one of 5 residents reviewed for administration of medications (Resident 262).</p> <p>Findings include:</p> <p>In an interview with Resident 262 on February 25, 2025, at 2:03 PM the resident indicated there was a mix up with her medications Zofran (a medication used to treat nausea and vomiting) and Ativan (a medication used to treat anxiety) from when she was at the facility the first time, and she should not have had them the second time.</p> <p>Clinical record review for Resident 262 revealed the resident was admitted to the facility on [DATE], and sent to the hospital after a change in condition on January 26, 2025.</p> <p>A progress note for Resident 262 dated January 27, 2025, at 12:39 PM noted facility staff met with a family member of the resident who was in the facility collecting the resident's personal belongings who indicated they had chosen to not hold the resident's bed at the facility and did not know how long the resident would be in the hospital.</p> <p>A review of Resident 262's medication orders prior to her transfer to the hospital on January 26, 2025, revealed the resident was ordered Lorazepam (Ativan) as needed for anxiety on January 24, 2025, and Zofran as needed for nausea on January 24, 2025, and both medications were discontinued from the orders on January 29, 2025, when the resident was not in the facility.</p> <p>Resident 262 was readmitted to the facility on [DATE], with several new diagnosis including Torsades de Pointes (a life-threatening heart rhythm disorder, which is noted to be caused by prolonged QT intervals, the time between the Q wave and the T wave of lower heart function) and medication orders. Resident 262's medication orders upon readmission from the hospital did not include Lorazepam (Ativan) or Zofran.</p> <p>A review of a controlled medication utilization record for Resident 262 for Lorazepam, revealed the sheet indicated the medication was received on January 25, 2025 (after the medication was ordered as noted above on January 24, 2025, during the resident's first admission to the facility). Documentation on the controlled medication record revealed a staff member documented the resident was administered a dose of the medication on February 9, 2025, at 7:53 PM.</p> <p>There was no documentation or evidence to indicate the resident was having anxiety at the time or before the administration of the Lorazepam on February 9, 2025, that the resident's physician was contacted due to the resident having anxiety, or that that resident had a physician's order to administer Lorazepam on February 9, 2025, as it was not ordered upon the resident's readmission to the facility. There was also no evidence on Resident's 262's medication administration record of the drug being administered, only the controlled medication sheet.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further clinical record review for Resident 262 revealed a late entry progress note dated February 12, 2025, at 6:52 PM for February 10, 2025, at 9:48 AM that noted during the morning medication pass the resident complained of not feeling well and was nauseous with ginger ale being given without helping. It was noted the on-call provider was called and a new order for a one-time dose of Zofran was obtained. The note indicated it was given and effective.</p> <p>There was no evidence in Resident 262's clinical record of a physician's order for the Zofran as noted above, or any documentation on the resident's medication administration record that the drug was administered as noted.</p> <p>A review of the Food and Drug Administration's (FDA) label for Zofran, revealed a drug label warning for QT interval prolongation and Torsade de Pointes to avoid in patients with congenital long QT syndrome, cardiac failure or arrhythmias. There was no evidence this warning was reviewed prior to the drug being administered as noted above on February 10, 2025.</p> <p>In an interview with the Director of Nursing (DON) on February 28, 2025, at 1:40 PM the DON indicated the above information was identified by the facility as a resident concern. They confirmed the Lorazepam was administered without a physician's order on February 9, 2025, and the medication card for Resident 262 remained in the facility accessible to staff even after the drug was discontinued on January 29, 2025, when the resident was hospitalized. It was confirmed the Lorazepam dose on February 9, 2025, was not noted as administered on the resident's medication administration record and only on the controlled substance sheet.</p> <p>In the same interview, the DON confirmed there was no evidence of a verbal/written physician's order to administer Zofran to Resident 262 on February 10, 2025, and there was no documentation on the resident's medication administration record to indicate the drug was administered. There was no evidence the staff member or provider if contacted, acknowledged or addressed the FDA warning regarding the resident's diagnosis of Torsades de Pointes and the Zofran before it was administered on February 10, 2025.</p> <p>Resident 262 did not exhibit an adverse reaction to the administration of the above medications.</p> <p>The facility provided evidence of counseling to the nurse who administered the Lorazepam without and order, and who did not document on the medication administration record that the drug was administered. Counseling was provided to the nurse who did not enter a physician's order for the resident to receive Zofran and document on the medication administration record that it was administered.</p> <p>The facility provided evidence of staff education regarding verbal orders to licensed staff although all staff were not yet educated at the time of review. There was no evidence of staff education regarding the disposition of resident medications upon discontinuation of a medication as the medication card containing Lorazepam remained available in the facility for Resident 262 on February 9, 2025, after the drug was discontinued on January 29, 2025.</p> <p>The above findings were reviewed with the Nursing Home Administrator on February 28, 2025, at 2:45 PM.</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code: 211.12(d)(1)(5) Nursing services.</p> <p>28 Pa. Code 211.9 (a)(1), (d), (j.1)(1)(3)(4)(5) Pharmacy services</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>29512</p> <p>Based on observation and staff interview, it was determined that the facility failed to ensure appropriate medication security for one of six nursing units (300 Hall Nursing Unit).</p> <p>Findings include:</p> <p>Observation of the 300 Hall Nursing Unit on February 25, 2025, revealed the following:</p> <p>At 8:48 AM, upon arrival to the 300 Hall Nursing Unit, the surveyor observed the unit's medication cart unlocked while it was near the soiled utility room. No licensed staff were observed in the vicinity. There were several unlicensed staff pushing residents in wheelchairs past the medication cart while it was unlocked.</p> <p>At 8:49 AM, Employee 1, licensed practical nurse, returned to the medication cart from down the hallway and out of view of the medication cart.</p> <p>Employee 1 left the 300 Hall Nursing Unit's medication cart while they were away from the medication cart and did not have direct visualization of the medication cart.</p> <p>Interview on February 25, 2025, at 9:18 AM with Employee 1 acknowledged that their medication cart was left unsecure while they were away from it.</p> <p>The findings were reviewed during an interview on February 26, 2025, at 9:00 AM with the Nursing Home Administrator and the Director of Nursing.</p> <p>28 Pa. Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(l)(3)(e)(1) Management</p> <p>28 Pa. Code 201.29 (c)(3)(4) Resident rights</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>36798</p> <p>Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to assist a resident to obtain routine dental care for one of two residents reviewed for dental concerns (Resident 84).</p> <p>Findings include:</p> <p>Interview and observation of Resident 84 on February 26, 2025, at 11:06 AM while she was in bed revealed that she had her own teeth. Resident 84 indicated that she had not seen a dentist since she had been in the facility.</p> <p>Clinical record review for Resident 84 revealed that her current payment source was the state Medicaid benefit.</p> <p>Further clinical record review for Resident 84 revealed no evidence of her receiving dental services over the past 12 months.</p> <p>Interview of the Director of Nursing on February 28, 2025, at 8:00 AM revealed that there was no evidence that Resident 84 received dental care or that she was offered dental care and refused treatment.</p> <p>The facility failed to provide Resident 84 with routine prophylactic dental cleanings as covered under the State plan.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38839</p> <p>Based on clinical record review and staff and resident interview, it was determined that the facility failed to ensure accurate clinical documentation for one of 24 residents reviewed (Resident 100).</p> <p>Findings include:</p> <p>Clinical record review for Resident 100 revealed the resident was admitted to the facility on [DATE]. Review of the resident's list of active diagnosis revealed Post Traumatic Stress Syndrome (PTSD) added on January 22, 2025.</p> <p>Review of an admission MDS (Minimum Data Set - an assessment completed at periodic intervals of time to assess resident care needs) dated January 28, 2025, for Resident 100 revealed the resident was listed as having a diagnosis of PTSD.</p> <p>Interview with Resident 100 on February 25, 2025, at 12:02 PM revealed the resident indicated hearing sirens specifically were traumatizing to him due to his history, but stated he did not have an official diagnosis of PTSD from a psychologist or medical professional.</p> <p>In an interview with Employee 2, social services, on February 27, 2025, at 10:30 AM, Employee 2 indicated Resident 100 did have a history of trauma with hearing sirens, which she addressed in his plan of care, but the resident did not have a diagnosis of PTSD.</p> <p>A social service progress note dated February 27, 2025, at 3:00 PM noted social service contacted Resident 100's medical providers and confirmed the resident did not have a diagnosis of PTSD and it would be removed from his list of diagnosis.</p> <p>Resident 100's clinical record inaccurately reflected that the resident had a diagnosis of PTSD.</p> <p>The above information was reviewed with the Nursing Home Administrator and Director of Nursing on February 27, 2025, at 3:30 PM.</p> <p>28 Pa. Code 211.5(i) Medical records</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		