

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395679	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/04/2024
NAME OF PROVIDER OR SUPPLIER  Grove at Washington, The		STREET ADDRESS, CITY, STATE, ZIP CODE  1198 W. Wylie Avenue Washington, PA 15301	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>31343</p> <p>Based on review of facility policy, observations, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information in one area (storage shed).</p> <p>Findings include:</p> <p>Review of the facility policy Confidentiality dated 1/31/24, indicated that residents have the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Review of the facility policy Medical Records Storage dated 1/31/24, indicated that all medical records will be stored in a secure, fire-protected, waterproof area.</p> <p>During an observation of a unsecured storage shed behind the facility on 6/4/24, at 8:15 a.m., approximately 75 boxes of loose paper, with resident information observed throughout the shed.</p> <p>During an interview on 6/4/24, at 8:17 a.m., Maintenance Director Employee E1 confirmed that the paperwork was stored in the storage shed due to lack of space, and the shed is left unsecured all the time.</p> <p>During an interview on 6/4/24, at 9:20 a.m., the Nursing Home Administrator confirmed that the facility failed to maintain the confidentiality of residents' medical information and failed to make certain the information was secured in one area(storage shed).</p> <p>28 Pa. Code 201.29(j) Resident rights.</p> <p>28 Pa. Code 211.5(b) Clinical records.</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>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> 31343</p> <p>Based on observations, and resident and staff interviews, it was determined that the facility failed to maintain a safe, clean, homelike environment on one of two nursing units(North Wing), and in the main dining room.</p> <p>Findings include:</p> <p>During observations on 6/4/24, from 8:45 a.m., through 9:45 a.m., the following was identified:</p> <p>Residents R1 and R2 had hole in he floor near baseboard by the bathroom.</p> <p>Residents R3 and R4 had areas of chipped paint under the window surrounding the heater.</p> <p>Residents R5 and R6 had a cracked ceiling above bed 2, Resident R6 stated the ceiling may leak through the hole, but I haven't seen any water.</p> <p>Resident room [ROOM NUMBER] currently empty had a broken wall plug plate in the bathroom.</p> <p>Residents R7 had unfinished drywall with spackling behind beds.</p> <p>The main dining room floor has multiple spots of brown substance and appears soiled with food debris.</p> <p>During an interview on 6/4/24, at 10:00 a.m., the Nursing Home Administrator and the Maintenance Director Employee E1 confirmed that the facility failed to maintain a clean, homelike environment on one of two nursing units (North Wing Nursing Unit) and in the main dining room.</p> <p>28 Pa. Code: 201.29(j)(k) Resident rights.</p> <p>28 Pa. Code: 207.2(a) Administrator's responsibility.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31343</p> <p>Based on review of facility policy, facility documentation, and staff interviews, it was determined that the facility failed to protect residents from neglect for one of two residents (Resident R8), by failing to follow physicians orders during incontinence pad change and linen change. This was identified as past non-compliance.</p> <p>Findings include:</p> <p>Review of the United States Code of Federal Regulations (CFR), 42 CFR S483.12. Freedom from Abuse, Neglect, and Exploitation defined neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.</p> <p>Review of the facility policy Abuse Protection dated 1/31/24, with a previous review date of 1/26/23, indicated that all resident have a right to be free from abuse, neglect, etc. and the facility is committed to protecting the residents from abuse by anyone providing services to the residents.</p> <p>Review of the clinical record indicated that Resident R8 was admitted to the facility on [DATE], with diagnoses which included diabetes, history of pulmonary blood clots, bacteremia and wound of her right leg. A Minimum Data Set(MDS- periodic review of resident care needs) dated 3/18/24, indicated the diagnoses remained current and Section G0110 (ADL's) indicated Resident R8 requires assistance of two staff for bed mobility. Resident R8 had an enabler bar on the left side of her bed.</p> <p>Review of a facility provided information in a report dated 5/16/24, indicated that Resident R8 had been receiving incontinence care and linen change when Nurse Aide (NA) Employee E2 rolled Resident R8 onto her right side where there was no enabler bar and onto the floor.</p> <p>Review of the incident report dated 5/16/24, indicated Resident R8's being rolled out of bed with enabler bar on left but not right side and one staff assisting her.</p> <p>Review of a statement dated 5/16/24, indicated NA Employee E2 had rolled Resident R8 to her right side toward the Nurse Aide and enabler bar then she rolled Resident R8 towards the left, Resident R8 rolled off edge of bed onto the floor. The Nurse Aide ran and got assistance from other staff.</p> <p>During an interview on 6/4/24, at 10:25 a.m., Resident R8 stated that she had told NA Employee E2 she did not feel comfortable rolling without a second person since there was not an enabler bar on the right side, but NA Employee E2 stated I got you.</p> <p>During an interview and observation on 6/4/24, at 1:30 p.m. NA Employee E3 was asked how she knows what level of staff assistance for bed mobility is appropriate for a resident. NA Employee E3 stated she looks on the kiosk and demonstrated on the kiosk how the information is found.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/4/24, at 1:32 p.m., Licensed Practical Nurse (LPN-Agency) Employee E4 was asked how she knows what level of staff assistance for bed mobility is appropriate for a resident. LPN Employee E4 stated that she looks at the clinical record as she does not document in the kiosk tasks.</p> <p>During an interview on 6/4/24, at 1:44 p.m. NA Employees E5, E6, E7 and E8 stated that they have access to the kiosk and that the information is found in there and they also share the information between shifts.</p> <p>During an interview on 6/4/24, at 2:30 p.m. the Nursing Home Administrator confirmed that the facility failed to protect a resident from neglect.</p> <p>On 5/16/24, the facility initiated education for all direct care nursing staff including Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Nurse Aides (NAs) to ensure that ordered transfer guidelines were understood and followed appropriately.</p> <p>This plan included the following:</p> <ul style="list-style-type: none"> <li>-Immediate re-education of NA Employee E2.</li> <li>-Facility completed a full house audit to ensure correct transfer statuses were documented for each resident.</li> <li>-Education was provided on 5/16/24 and 5/20/24, to all facility staff on abuse and neglect.</li> <li>-Audits and education were reviewed with the Quality Assurance and Performance Improvement Committee for trends and outcomes.</li> </ul> <p>The facility has demonstrated compliance with the regulation since 5/31/24.</p> <p>During an interview on 6/4/24, at 2:45 p. m., with the Nursing Home Administrator and Director of Nursing, and review of the facility's immediate actions, education, and review of the QAPI monitoring process to sustain solutions, it was verified that the facility had implemented a plan of correction and achieved compliance ensuring the prevention of resident neglect.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 201.20(b)(1) Staff Development.</p> <p>28 Pa. Code 201.29(a) Resident rights.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.11(d) Resident care plan.</p> <p>28 Pa Code 211.12(d)(1)(2)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31343</p> <p>Based on review of facility policy, clinical records, facility documentation, and resident and staff interviews, it was determined that the facility failed to provide adequate supervision and implement effective bed mobility interventions as per physician order to promote resident safety, for one of two residents (Resident R8). This deficiency is cited as past non-compliance.</p> <p>Findings include:</p> <p>Review of facility policy entitled Accidents and Incidents- Investigating and Recording, dated 1/31/24, indicated that all incidents and accidents occurring on the premises must be investigated and reported to the administrator. Regardless of the incident/accident, staff are to render immediate assistance, conduct an initial assessment and provide emergency interventions and if necessary, call 911. An employee witnessing an accident or incident involving a resident must report such occurrence to his or her supervisor immediately. Do not leave the victim unattended unless necessary to summon assistance. A witness statement is to be obtained and the Supervisor must be informed so that medical attention can be provided.</p> <p>Review of the clinical record indicated that Resident R8 was admitted to the facility on [DATE], with diagnoses which included diabetes, history of pulmonary blood clots, bacteremia and wound of her right leg. A Minimum Data Set(MDS- periodic review of resident care needs) dated 3/18/24, indicated the diagnoses remained current and Section G0110 (ADL's) indicated Resident R8 requires assistance of two staff for bed mobility. Resident R8 had an enabler bar on the left side of her bed.</p> <p>Review of a facility provided information in a report dated 5/16/24, indicated that Resident R8 had been receiving incontinence care and linen change when Nurse Aide (NA) Employee E2 rolled Resident R8 onto her right side where there was no enabler bar and onto the floor.</p> <p>Review of the incident report dated 5/16/24, indicated Resident R8's being rolled out of bed with enabler bar on left but not right side and one staff assisting her.</p> <p>Review of a statement dated 5/16/24, indicated NA Employee E2 had rolled Resident R8 to her right side toward Nurse Aide Employee E2 and enabler bar then she rolled Resident R8 towards the left, Resident R8 rolled off edge of bed onto the floor.</p> <p>During an interview on 6/4/24, at 10:25 a.m., Resident R8 stated that she had told NA Employee E2 she did not feel comfortable rolling without a second person since there was not an enabler bar on the right side, but NA Employee E2 stated I got you.</p> <p>During an interview and observation on 6/4/24, at 1:30 p.m. NA Employee E3 was asked how she knows what level of staff assistance for bed mobility is appropriate for a resident. NA Employee E3 stated she looks on the kiosk and demonstrated on the kiosk how the information is found.</p> <p>(continued on next page)</p>		

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