

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/24/2024
NAME OF PROVIDER OR SUPPLIER  Wallingford Skilled Nursing and Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 115 South Providence Road Wallingford, PA 19086	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>30934</p> <p>Based on review of facility policy and procedure, clinical record, and staff interview it was determined the facility failed to thoroughly investigate an injury of unknown origin for one of 24 residents reviewed. (Resident 264)</p> <p>Findings include:</p> <p>Review of Facility policy and procedure titled Accidents/Incidents, last revised on March 1, 2024 revealed, When conducting an investigation the Administrator, DON, or designee will make every effort to ascertain the cause of the accident/incident .Conduct witness interviews from all staff and visitors who may have knowledge of the accident/incident.</p> <p>Review of Resident 264 progress notes revealed a nursing entry dated February 21, 2024 at 1:44 p.m. stating, during rounds resident grimacing and moaning when left lower extremity moved, resident have limited to no movement of left leg, NP (Nurse Practitioner) seen and examined and resident with new order for stat (immediate) x-ray of the left hip, pelvis, and femur and knee.</p> <p>Further review of Resident 264 progress notes revealed a nursing entry on February 21, 2024 at 4:48 p.m. stating x-ray results received: moderately displaced intertrochanteric fracture of the left hip (hip fracture). New orders to send to the ER (emergency room ).</p> <p>Review of the Incident Report for the injury to Resident 264 on February 21, 2024 revealed the resident was found to be non-mobile this am. STAT (meaning - immediately) x-rays ordered and resulted positive for moderately displaced fracture of the left hip. There were no witnesses listed and two statements from an LPN and a CNA who worked the 3-11 shift on February 20, 2024 and stated the resident was ambulating normally and provided no information as to the possible cause of the injury.</p> <p>The facility failed to conduct a thorough investigation by not interview staff who cared for the resident on the shift the injury was identified, or the previous night shift staff assigned to the resident and were unable to determine a timeline of when the injury could have occurred or the cause of the injury.</p> <p>Interview with the Director of Nursing on June 24, 2024 at 1:30 p.m., confirmed the investigation into Resident 264 hip fracture was not thoroughly completed.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management</p> <p>28 Pa. Code 201.29(a)(d) Resident Rights</p> <p>28 Pa. Code 211.5(f) Clinical Records</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>41765</p> <p>Based on clinical records review and staff interview, it was determined that the facility failed to ensure medication ordered by the physician was followed for one of the 33 residents reviewed (Resident 70).</p> <p>Findings include:</p> <p>Review of Resident 70's diagnosis list includes Chronic Kidney Failure and Dependence on Hemodialysis (A process of purifying the blood of a person whose kidneys are not working normally).</p> <p>Review of Resident 70's clinical record revealed the resident goes for dialysis services every Tuesday, Thursday, and Saturday at 10:00 a.m.</p> <p>Review of the Resident 70's blood work dated June 4, 2024, revealed a Phosphorus level of 6.8 mg/dl (normal range 2.5- 4.5)</p> <p>Review of Resident 70's physician's orders dated June 2, 2024, and June 13, 2024, revealed an order for Calcium Acetate (Phosphate binder) 667 mg one tablet by mouth with meals for elevated phosphorus. The medication was scheduled for 8:30 a.m., 12:30 p.m., and 5:00 p.m.</p> <p>Review of Resident 70's medication administration record revealed that the medication was not administered on June 4, 6, 15, 18, and 20, 2024, at 12:30 p.m.</p> <p>Interview with the Director of Nursing conducted on June 15, 2024, revealed that the medication was not administered due to the resident being out of the facility for dialysis.</p> <p>The clinical records review failed to reveal the physician was notified of the missed medication until June 24, 2024.</p> <p>The facility failed to ensure medication (Calcium Acetate) to treat elevated Phosphorus was followed.</p> <p>28 Pa. Code 211.5(f) Clinical Records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p>		

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<p>F 0689</p> <p>Level of Harm - 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> 30934</p> <p>Based on clinical record review, facility policy and procedure review, and staff interview it was determined the facility failed to accurately assess and identify a newly admitted resident as a fall risk and develop interventions to prevent falls causing actual harm to Resident 263 who fell causing injuries that required hospitalization for one of 3 residents reviewed (Resident 263)</p> <p>Findings include:</p> <p>Review of facility policy and procedure titled Assessment: Nursing last revised March 2022, revealed A nursing assessment will be performed by a licensed nurse for all patients within 24 hours of admission. Routine and focused assessments will be performed on an ongoing basis as needed. Assessments will be reviewed and certified as completed by an RN within 24 hours and all individuals who complete a portion of the assessment will sign and certify to the accuracy of the portion of the assessment, he/she completed.</p> <p>Review of Resident 263's clinical record revealed the resident was admitted to the facility on [DATE] from the hospital.</p> <p>Review of Resident 263's documentation from the hospital revealed the resident went to the hospital and was admitted after a near syncope (fainting) episode during which she was hypotensive (low blood pressure) and had difficulty getting into her house. Further review of the hospital documentation revealed the resident was discharged with a diagnosis of Hypotension and Syncope.</p> <p>Review of Resident 263's physical therapy documentation while in the hospital revealed the resident was determined to be at risk for falls and to have ambulation deficits, balance deficits, bed mobility deficits, strength deficits, transfer deficits and safety awareness deficits.</p> <p>Review of Resident 263's facility diagnosis list revealed diagnosis of Hypotension (low blood pressure), Syncope (sudden, temporary drop in the amount of blood that flows to the brain), and collapse.</p> <p>Review of Resident 263's Vital Signs revealed a blood pressure on December 17, 2023 at 9:32 P.M. of 102/45 (normal 120/80).</p> <p>Review of Resident 263's admission assessment dated [DATE] revealed the resident was determined to have no risk factors for falls related to history or fear of falls or factors such as current diagnosis or medications that would increase the risk for falls and there was no risk for falls due to the resident's presence or history of gait, strength, or balance factors.</p> <p>Review of Resident 263's progress notes revealed a nursing entry dated December 18, 2023 at 2:53 a.m. that indicated CNA (Certified Nursing Assistant) heard a noise and went into the room to check on patient and found her on the floor face down next to the bed. R (right) facial laceration at smile line measuring 4 cm (centimeters) and one of R eye measuring 1.5 cm. Peri orbital (eye) swelling noted on right side. EMS (Emergency Medical Services) called at 0233 (2:33 a.m.).</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Review of Resident 263's care plan revealed there was no care plan developed for risk for falls or interventions in place prior to the fall of December 18, 2023.</p> <p>Resident 263 was inaccurately assessed at the time of admission as not being at risk for falls and there were no interventions in place to prevent falls leading to a fall with major injury that required hospitalization on [DATE].</p> <p>This information above was relayed to the Nursing Home Administrator on June 24, 2024 at 1:15 p.m.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management</p> <p>28 Pa. Code 201.29(c) Resident rights</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>28 Pa. Code 211.11(d) Resident care plan</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>30934</p> <p>Based on clinical record review, it was determined that the facility failed to monitor and address significant weight changes in a timely manner for two of six residents reviewed for nutrition (Residents 54 and 60).</p> <p>Findings include:</p> <p>Review of Resident 54's weights revealed the resident had not been weighed since April 24, 2024.</p> <p>Review of Resident 54's progress notes revealed a dietitian entry dated May 20, 2024 stating No updated weight this month. Rt refused to be weighed Attempted to get weight again today but sit to stand scale is broken.</p> <p>Review of Resident 54's clinical record revealed there was no other documentation of resident refusing to be weighed and there was no care plan developed for the resident related to refusals.</p> <p>Interview with the Director of Nursing confirmed Resident 54 had not been weighed since April 24, 2024 and there was no other documented evidence Resident 54 had refused weights.</p> <p>Interview with the Nursing Home Administrator on June 24, 2024 at 1:15 p.m. revealed the maintenance director had inspected the scale used for Resident 54 and it was in working order.</p> <p>The facility failed to get at least monthly weight of Resident 54 to properly evaluate his nutritional status.</p> <p>Observation of Resident 60 on June 20, 2024, at 9:00 a.m. revealed the resident had a PEG tube (percutaneous endoscopic gastrostomy - plastic tube inserted into the stomach to provide nutrition, hydration, and medication).</p> <p>Review of Resident 60's care plan initiated November 6, 2016, revealed the resident was identified as at risk for alteration in nutrition status related to anoxic brain injury, dysphagia (difficulty swallowing), and the need for enteral nutrition, with an intervention to review weights and to notify the physician and responsible party of significant weight changes.</p> <p>Review of Resident 60's weights revealed on June 2, 2024, the resident was recorded as weighing 147.6 pounds (lbs.). On June 4, 2024, the resident was recorded as weighing 158 lbs., a 10.4 lb., or 7.05% weight gain in two days.</p> <p>Review of Resident 60's progress notes revealed a nutrition note on June 19, 2024, which stated: Brief weight change note. Resident shows potential 7% wt gain x 2 days, and x 1 month, which is significant. Wts reviewed: 158# (6/4), 147.6# (6/2), 147.8# (5/3). Resident will need reweight to confirm 10.4# wt gain x 2 days. Reweight requested. No edema noted. Full weight change/nutrition assessment to follow once reweight is obtained and sig wt change is confirmed.</p> <p>Review of Resident 60's weights as of June 24, 2024, failed to reveal that a reweight was obtained.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Director of Nursing on June 24, 2024, at approximately 1:20 p.m. failed to reveal an explanation as to why a reweight for Resident 60 was not obtained.</p> <p>28 Pa. Code 211.5(f) Clinical Records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p> <p>28 Pa Code: 211.10(c) Resident care policies</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>30934</p> <p>Based on Clinical record review and staff interview it was determined the facility failed to provide enteral nutrition (feeding delivered through a feeding tube) as ordered by the physician for one of five residents reviewed. (Resident 54)</p> <p>Findings include:</p> <p>Review of Resident 54's clinical record revealed the resident returned from the hospital on February 28, 2024 with a PEG tube (feeding tube- tube surgically inserted into the stomach when oral intake is not adequate).</p> <p>Review of the physician orders revealed an order dated April 24, 2024 for Jevity 1.5 (tube feeding) running at 65 ml per hour starting at 5 p.m. and ending at 9 a.m. for a total of 1040 ml per day.</p> <p>Review of resident 54's Medication Administration Record (MAR) for the months of April, May and June 2024 revealed there were no days where it was documented the resident received a total of 1040 ml per day as ordered by the physician.</p> <p>Interview with the Director of Nursing on June 24, 2024 at 11:15 a.m. confirmed there was no documented evidence Resident 54 had received the amount of tube feeding as ordered by the physician.</p> <p>28 Pa Code: 211.5(f) Clinical records</p> <p>28 Pa code: 211.12(d)(1)(3)(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47968</p> <p>Based upon clinical record review, it was determined that the facility failed to ensure that medication irregularities were acted upon by a physician for four of five residents reviewed (Resident 16, 29, 77, and 137).</p> <p>Findings include:</p> <p>Review of Resident 16's Consultation Report for the Medication Regimen Review completed on September 1, 2023, revealed a recommendation to consider a trial dose reduction of Aripiprazole (anti-psychotic medication) to 2 mg at night.</p> <p>Review of Resident 16's clinical record failed to reveal that the above recommendation was addressed by the physician.</p> <p>Interview with the Director of Nursing on June 25, 2024, at 1:00 p.m., confirmed that the pharmacy recommendation made on September 1, 2024, was not addressed by the physician.</p> <p>Review of Resident 29's Consultation Report for the Medication Regimen Review completed on February 1, 2024, revealed a recommendation for a dose reduction evaluation for the medications Clonazepam (Anti-anxiety medication), Haloperidol (Anti-psychotic medicines), and Escitalopram (ant-depressant medication).</p> <p>Review of Resident 29's clinical record failed to reveal that the above recommendation was addressed by the physician.</p> <p>Interview conducted with the DON on June 25, 2024, at 1:00 p.m., confirmed that the pharmacy recommendations made on February 1, 2024, were not addressed by the physician.</p> <p>Review of Resident 77's Consultation report for the Medication Regimen Review completed on May 4, 2024 revealed the pharmacist recommended the facility only order as needed Xanax (anti-anxiety medication) for a duration of 14 days per CMS (Centers for Medicare and Medicaid) regulations. This recommendation was not addressed by the physician until June 24, 2024.</p> <p>Interview conducted with the Director of Nursing on June 24, 2024 at 1:35 p.m. confirmed Resident 77 recommendations from the pharmacist on May 4, 2024 was not addressed timely.</p> <p>Review of Resident 137's clinical record revealed Resident 137 was admitted into the facility on [DATE], with a BIMS (Brief Interview of Mental Status) score of 3, indicating severely impaired cognition.</p> <p>Review of Resident 137's clinical record including admission diagnoses of Dementia with Agitation, Dysphagia (swallowing disorder), Restlessness, Agitation, Psychosis, Depression, Seborrhea Capitis (skin condition), Anemia (low blood cells), and Hypokalemia (low potassium).</p> <p>(continued on next page)</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>Review of Resident 137's clinical records revealed a physician order dated February 23, 2023, for Haloperidol Oral Tablet 1 mg. for psychosis.</p> <p>Review of Resident 137's clinical records revealed a physician order dated June 2, 2023, for Olanzapine Oral Tablet 5 mg. for dementia with agitation.</p> <p>Further review of Resident 137's clinical records revealed a physician order dated June 20, 2023, for Mirtazapine Tablet 7.5 mg. for depression.</p> <p>Review of Resident 137's clinical record revealed that a MRR (Medication Record Review) was completed on January 4, 2024, with two recommendations, 1.) semi-annual dose reduction evaluation requested for the above medications, (Haloperidol 1mg, Olanzapine 5mg, Mirtazapine 7.5 mg). 2.) Periodically reevaluate [NAME] antipsychotic use.</p> <p>Further review of Resident 137's clinical record revealed that a MRR (Medication Record Review) was completed on May 10, 2024, with the recommendation, trial dose reduction of the above medications requested, (Haloperidol 1mg, Olanzapine 5mg, Mirtazapine 7.5 mg).</p> <p>Review of Resident 137's clinical record failed to reveal documented evidence the pharmacist recommendations were addressed by the attending physician.</p> <p>Interview with the Director of Nursing on June 24, 2024, at 1:35 p.m. confirmed there was no documented evidence of a response by the physician to the recommendations made by the consultant pharmacist.</p> <p>483.45 Drug Regimen Review, Report Irregular, Act on</p> <p>Previously cited 11/1/21, 12/30/22, 3/24/23, 8/25/23, 10/23/23</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>Previously cited 11/1/21, 12/30/22, 3/24/23, 8/25/23, 10/23/23</p> <p>483.45 Drug Regimen Review, Report Irregular, Act on</p> <p>Previously cited 11/1/21, 12/30/22, 3/24/23, 8/25/23, 10/23/23</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>Previously cited 11/1/21, 12/30/22, 3/24/23, 8/25/23, 10/23/23</p> <p>28 Pa. Code 211.12(c) Nursing Services</p> <p>Previously cited 8/25/23, 10/23/23,</p> <p>28 Pa. Code 211.12(d)(3) Nursing Services</p> <p>Previously cited 4/4/2023, 8/25/23, 10/23/23,</p> <p>(continued on next page)</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>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p> <p>Previously cited 8/25/23, 10/23/23</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>37789</p> <p>Based on clinical record review, it was determined that the facility failed to ensure non-pharmalogical interventions (NPIs) were attempted prior to the administration of as-needed narcotic pain medication for one of thirty-three residents reviewed (Resident 98).</p> <p>Findings include:</p> <p>Review of Resident 98's physician's orders revealed an order dated October 25, 2023, for oxycodone (narcotic pain reliever) 5 milligrams (mg) give every 4 hours as needed, and document all NPIs prior to administering the medication.</p> <p>Review of Resident 98's April 2024 Medication Administration Record (MAR) revealed the resident received as-needed oxycodone 5 mg a total of 21 times. Review of Resident 98's May 2024 MAR revealed the resident received as-needed oxycodone 5 mg a total of 20 times. Review of Resident 98's June 2024 revealed the resident received as-needed oxycodone 5 mg a total of 26 times as of June 21, 2024.</p> <p>Further review of Resident 98's April 2024, May 2024, and June 2024 MARs and progress notes failed to reveal NPIs were documented prior to administering the resident's oxycodone 5mg.</p> <p>Interview with the Director of Nursing on June 24, 2024, at approximately 1:25 p.m. confirmed the facility failed to document NPIs prior to administering Resident 98's as-needed pain medication.</p> <p>28 Pa Code 211.5 (f) Clinical records</p> <p>28 Pa code 211.10 (c) Resident care policies</p> <p>28 Pa. 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47968</b></p> <p>Based upon clinical record review, it was determined that the facility failed to ensure residents were free from unnecessary psychotropic medications by attempted dosage reductions and periodical reevaluation of psychotropic drug usage for three of five residents reviewed (Residents 16, 29, and 137).</p> <p>Findings include:</p> <p>Review of the facility's policy titled Psychotropic Medication Use dated December 1, 2007, revealed the facility should ensure that the ordering physician reviews the medication plan and considers a Gradual Dose Reduction (GDR) of psychotropic medications to find the lowest effective dose unless a GDR is clinically contraindicated. The physician should document the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.</p> <p>Review of Resident 16's physician order dated September 1, 2023, revealed an order for Aripiprazole (anti-psychotic medication) 5 mg (milligram) given by mouth at bedtime for Major Depressive Disorder (MDD).</p> <p>Review of Resident 16's clinical record failed to reveal the facility attempted to do a GDR for Resident 16's Aripiprazole.</p> <p>Interview with the Director of Nursing (DON) on June 24, 2024, at 1:00 p.m., confirmed there was no attempt to perform GDR of Aripiprazole medication and no documentation of a physician's rationale for Resident 16.</p> <p>Review of Resident 29's physician order dated March 31, 2016, revealed an order for Klonopin tablet (Anti-anxiety medication) 0.5 mg give one tablet by mouth at bedtime for anxiety,</p> <p>Review of Resident 29's physician order dated July 1, 2021, revealed an order for Lexapro (Anti-depressant medication) 20 mg by mouth one time a day for depression.</p> <p>Review of Resident 29's physician order dated October 6, 2021, revealed an order for Haloperidol Lactate Concentrate 2mg/ml given 1mg by mouth at bedtime for Dementia with behavioral disturbances.</p> <p>Clinical records review failed to reveal that the facility attempted to do GDR for the Klonopin, Lexapro, and Haloperidol medication for Resident 29.</p> <p>Interview with the Director of Nursing (DON) on June 24, 2024, at 1:00 p.m., confirmed that there was no attempt to perform GDR on Klonopin, Lexapro, and Haloperidol medications and no documentation of a physician's rationale for not attempting the GDR for Resident 29.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/24/2024
NAME OF PROVIDER OR SUPPLIER  Wallingford Skilled Nursing and Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE  115 South Providence Road Wallingford, PA 19086	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 137's clinical record revealed Resident 137 was admitted into the facility on [DATE], with a BIMS (Brief Interview of Mental Status) score of 3, indicating severely impaired cognition.</p> <p>Review of Resident 137's admission diagnoses revealed Dementia with Agitation, Dysphagia (difficulty swallowing), Restlessness, Agitation, Psychosis, Depression, Seborrhea Capitis (skin condition consisting of scaly patches, inflamed skin affecting oily areas of the body), Anemia (low blood cells), and Hypokalemia (low potassium).</p> <p>Review of Resident 137's clinical records revealed a physician order dated February 23, 2023, for Haloperidol Oral Tablet 1 mg for psychosis.</p> <p>Review of Resident 137's clinical records revealed a physician order dated June 2, 2023, for Olanzapine Oral Tablet 5 mg. for dementia with agitation.</p> <p>Further review of Resident 137's clinical records revealed a physician order dated June 20, 2023, for Mirtazapine Tablet 7.5 mg. for depression.</p> <p>Review of Resident 137's clinical record revealed that a MRR (Medication Record Review) was completed on January 4, 2024, with two recommendations, 1.) semi-annual dose reduction evaluation requested for the above medications, (Haloperidol 1mg, Olanzapine 5mg, Mirtazapine 7.5 mg). 2.) Periodically reevaluate [NAME] antipsychotic use.</p> <p>Further review of Resident 137's clinical record revealed that a MRR (Medication Record Review) was completed on May 10, 2024, with the recommendation, trial dose reduction of the above medications requested, (Haloperidol 1mg, Olanzapine 5mg, Mirtazapine 7.5 mg).</p> <p>Review of Resident 137's clinical record failed to reveal documented evidence a trial dose reduction or a semi-annual dose reduction evaluation was performed.</p> <p>Further review of Resident 137's clinical records failed to reveal documented evidence of periodical evaluations for dual antipsychotic drug usage was performed.</p> <p>Interview with the Director of Nursing on June 24, 2024, at 1:35 p.m. confirmed there was no documented evidence that trial dose reductions, semi-annual dose reductions or periodical evaluations for dual antipsychotic drug usage was performed for Resident 137.</p> <p>483.45 Drug Regimen Review, Report Irregular, Act on</p> <p>Previously cited 11/1/21, 12/30/22, 3/24/23, 8/25/23, 10/23/23</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>Previously cited 11/1/21, 12/30/22, 3/24/23, 8/25/23, 10/23/23</p> <p>28 Pa. Code 211.12(c) Nursing Services</p> <p>Previously cited 8/25/23, 10/23/23</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 211.12(d)(3) Nursing Services</p> <p>Previously cited 4/4/2023, 8/25/23, 10/23/23</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p> <p>Previously cited 8/25/23, 10/23/23</p>

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>41765</p> <p>Based on clinical records review and staff interview, it was determined that the facility failed to perform laboratory services for one of the 33 residents reviewed (Resident 29).</p> <p>Findings include:</p> <p>Review of Resident 29's clinical records revealed Resident 29 had a diagnosis of Epilepsy (disorder in which nerve cell activity in the brain is disturbed causing seizures).</p> <p>Review of Resident 29's physician order dated August 26, 2022, revealed an order for Depakote 750 mg in the morning and 500 mg at bedtime.</p> <p>Review of Resident 29's physician's notes dated April 29, 2024, at 9:30 a.m., revealed Today's order: TSH, CBC, CMP, and Depakote level for May 1, 2024.</p> <p>Review of Resident 29's physician's notes dated May 22, 2023, at 3:49 p.m., revealed the Depakote level was ordered but not completed on May 1, 2024, then reorder for May 2023.</p> <p>Clinical records review failed to reveal that Depakote level was completed on May 1, 2024, and/or May 23, 2024.</p> <p>An interview conducted with the Director of Nursing on June 24, 2024, at 1:00 p.m., confirmed Depakote level was not completed until June 22, 2024.</p> <p>The facility failed to ensure Resident 29's Depakote level was completed.</p> <p>28 Pa. Code 211.5(f) Clinical Records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p>

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.</p> <p>37789</p> <p>Based on clinical record review, it was determined that the facility failed to ensure the radiological diagnostic studies were done in a timely manner for one of thirty-three residents reviewed (Resident 101).</p> <p>Findings include:</p> <p>Review of Resident 101's progress notes revealed a nurse's note dated April 2, 2024, which stated: Resident return from schedule [doctor] appointment. Per [doctor] recommendation to check vitamin D level, increased vitamin D to 2000, Calcium 600 mg, Prolia [(medication used to treat bone loss)] injection [every] six months. Next office visit May 2024 for Dexa scan [(low-dose x-ray that measures bone density and risk for osteoporosis and fractures.)]</p> <p>Further review of Resident 101's progress notes revealed a nurse's note dated May 20, 2024, which stated: Resident was supposed to go out on appointment this afternoon, transport did not show- up.</p> <p>Further review of Resident 101's progress notes revealed a late entry nurse's note effective date May 20, 2024, which stated: Resident was scheduled for a dexascan today. The order was placed for stretcher transport, [transportation company] called and said they cannot do stretcher today but could we send her in a wheelchair with an escort. We sent her via [wheelchair] with [nurse aide] escort but they were unable to complete the procedure due to not being able to get resident on table for testing. Upon arrival back at facility the scheduler was made aware of need for dexa scan to be rescheduled.</p> <p>Further review of Resident 101's progress notes revealed a late entry nurse's note effective date June 17, 2024, which stated: Transportation called to say they could not take resident to her appointment by stretcher as ordered but could take her by [wheelchair]. This nurse agreed that she could try it and go by [wheelchair] with an escort. Resident went for her dexascan appointment but was unable to be transferred to the table for test. Resident came back to [the] facility and request for another appointment sent.</p> <p>Further review of Resident 101's progress notes revealed a nurse's note dated June 24, 2024, which stated: Resident is scheduled for her dexascan this Friday [(June 28, 2024)].</p> <p>Interview with the Director of Nursing on June 24, 2024, at 12:05 p.m. confirmed that Resident 101's DEXA scan was delayed twice due to the resident being unable to transfer to the table from the wheelchair.</p> <p>Pa. Code: 211.12(b) Nursing services</p> <p>Pa. Code: 211.12(d)(1)(3) (5) Nursing services</p> <p>Pa. Code: 211.10(d) Resident care policies</p>		