

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395690	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024
NAME OF PROVIDER OR SUPPLIER Springfield Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 463 West Sproul Road Springfield, PA 19064	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609</p> <p>Based on observations, review of facility policy, and interviews with staff and residents, it was determined that the facility did not ensure that residents were treated with dignity and respect for two of two residents reviewed. (Residents R13 and R47)</p> <p>Findings Include:</p> <p>Review of the Resident Rights policy with a revision date of October 2010 states, Purpose-To provide general guidelines for resident rights while caring for the resident.</p> <p>Preparation</p> <p>1. Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including:</p> <ul style="list-style-type: none"> a. Preventing, recognizing and reporting resident abuse; b. Resident dignity and respect; c. Resident notification of rights, services, and health/medical condition; d. Protection of resident funds and personal property; e. Confidentiality of protected health information; f. Resident right of refusal (medications and treatments); g. Use of restraints; h. Resident freedom of choice; i. Resident/Family participation in care planning; j. Resident access to information; and <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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>k. Visitation.</p> <p>A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>On May 16, 2024 Resident R13's clinical record was reviewed and there was an new order for the resident to be weighed weekly for four weeks on Wednesdays's starting May 15, 2024 due to the resident having a significant weight loss over the period of one month. Review of the resident's record showed the resident was not weighed on May 15, 2024 and there was no documentation of any refusal.</p> <p>On May 16, 2024 at 12:10 p.m. licensed nurse Employee E5 was questioned as to why Resident R13's weight was not taken on the day prior May 15, 2024. Licensed nurse Employee E5 stated she was not sure but she would have the nurses aides complete it now. The surveyor went into the room to talk with Resident R13 and Resident R13's sister who was present in the room at the time. Licensed nurse Employee E5 came into the room at 12:15 p.m. and discussed the resident being difficult to care for while in front of the resident and the resident's sister.</p> <p>Review of Resident R47 admissions Minimum Data Set (MDS- an assessment of residents' needs) dated May 4, 2024, indicated he was admitted to the facility on [DATE]. The resident was assessed as alert and oriented, able to make needs known, and with the diagnoses of hemiplegia (one side weakness) following a cerebral infarction (stroke) effecting the left side.</p> <p>Review of facility documentation and the witness statement from the Food Service Director, Employee E3 indicated on May 10, 2024 the Social Worker, Employee E14 went to the facility's kitchen to order Resident R47's request for extra breakfast food. The social worker left the kitchen to deliver the food to Resident R47. Approximately fifteen minutes later Resident R47 went to the kitchen and made a duplicate request for breakfast The Food Service Director told the resident he just sent food to his room but Resident R47 told him he never got it. The witness statement from the Food Director stated, That was a lot of stuff sent to him and we weren't giving him anymore food until lunch. The resident told him again he did not get his food and the Food Service Director told the resident to Leave the kitchen. The resident said he was not going to leave the kitchen until he got what he asked for, but the Director told him he wasn't going to get it. The resident asked who do you think you are? The Director said I am the boss of this food and he refused to give him another thing until lunch.</p> <p>On May 16, 2024 at 2:00 p.m. the Social Worker confirmed the resident was not in his room when she delivered the food.</p> <p>On May 16, 2024 at 2:34 p.m. the Food Service Director confirmed the witness statement was correct but he was not aware the resident was not in his room when the food was delivered. The Food Service Director stated, If I could do it again differently I would. I didn't know he felt he didn't get his meal. It would have been better to just give it to him.</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>47975</p> <p>Based on observation, it was determined that the facility failed to maintain a safe, clean, comfortable and homelike environment for 16 out of 21 residents reviewed. (Residents R42, R44, R28, R4, R63, R43, R329, R52, R35, R51, R19, R7, R44, R58, R30 and R34).</p> <p>Findings Include:</p> <p>An initial tour was taken on May 14, 2024 at 10:00 a.m. of n the East and North units revealed the following:</p> <p>Observation of Resident R35's room revealed an air conditioning unit that had liquid spilled on top of it.</p> <p>Observation of Resident R51's room at 10:04 a.m. revealed her call bell hanging on the wall and not within reach of her, this was confirmed by licensed nurse, Employee E6 at 10:08 a.m.</p> <p>A tour of Resident R42's room revealed trash on the floor and linens that were dirty. An interview with the resident revealed the facility phone in his room doesn't work. The resident stated the phone has not been working for about two weeks.</p> <p>A tour of Resident R51's room revealed the call bell on the floor out of reach of the resident, this was confirmed at 10:21 a.m. by licensed nurse Employee E6. Further observation of the resident's room revealed an applesauce on the dresser dated May 4, 2024 and a trash can with gloves, medicines cups, and spoons in it with no trash can liner.</p> <p>An interview was held with Resident R44 and the resident stated the facility phone in their room hasn't been working for around two and a half weeks.</p> <p>A tour of Resident R28's room revealed gloves in the trash can with the trash can having no liner. Further observation of the room revealed trash on the floor including gloves and food particles.</p> <p>A tour of Resident R4's room revealed a trash can that was overflowing with trash. An interview with the resident revealed the facility phone in her room hasn't been working for a week at least.</p> <p>A tour of Resident R63's room revealed wet soiled linens on the floor between the bed and the window. Further observation of the room also revealed brown streaks on the floor at the end of the bed.</p> <p>A tour of Resident R43's room revealed trash on the floor in room and an air conditioning unit that with top grates that were bent and not in place.</p> <p>A tour of Resident R329's room revealed a trash can that was full with no liner and a laundry basket that was full with laundry piled on top of the lid leaning against the dresser.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A tour of Resident R52's room revealed trash on the floor including a take-out food bag and paper trash.</p> <p>A tour of Resident R19's room revealed that her call bell was on the floor and there was no clip to hold it up.</p> <p>An interview with Resident R7 revealed that her phone had not been working for over two weeks.</p> <p>An interview with Resident R44 revealed that her phone had not been working for over two weeks.</p> <p>A tour of Resident R58's room revealed that her baseboard heater was bent and coming off the wall.</p> <p>A tour of Resident R30's room revealed that his call bell was on the floor. Interview with nurse aide, Employee E8 at 10:15 a.m. confirmed that the resident's call bell was on the floor.</p> <p>A tour of Resident R34's room revealed that his call bell was on the floor. Interview with nurse aide, Employee E8 at 10:15 a.m. confirmed that the resident's call bell was on the floor.</p> <p>The Nursing Home Administrator,, Employee E1 confirmed on May 16, 2024 at 1:12 p.m. that the phones on the East Wing have not been working since April 30, 2024. A calendar was provided to prove what date the phones stopped working.</p> <p>28 Pa Code 201.14 (a) Responsibility of licensee</p> <p>28 Pa Code 201.18(b)(1) Management</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609</p> <p>Based on review of clinical records, interviews with staff and review of facility policy, it was determined that the facility failed to develop a comprehensive person-centered care plan for three of 21 resident reviewed (Residents R32, R46 and Resident 48).</p> <p>Findings include:</p> <p>Review of facility policy titled Care Plans, Comprehensive Person-Centered revised on March 2022, states that it includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs and is developed and implemented for each resident.</p> <p>Review of Resident R32's clinical record revealed that the resident was admitted to the facility on [DATE], with the diagnosis of Type Two Diabetes Mellitus (a chronic condition that causes high blood glucose levels (hyperglycemia).</p> <p>Review of Resident R32's progress notes revealed on February 9, 2024 the resident was transferred to the hospital when he was hypoglycemic (low blood glucose levels) and found with fecal impaction (chronic constipation, hard dry stool stuck in the rectum).</p> <p>Further review of Resident R32's clinical record revealed the facility failed to develop a person-centered care plan related to the resident's chronic constipation.</p> <p>Review of Resident R46's clinical record revealed the resident was admitted on [DATE] due to a fall from home needing hospitalization and lymphoma (cancer involving the lymphatic system).</p> <p>Review of Resident R46's physician's progress note dated March 29, 2024 stated in the hospital the resident had suicide ideations and was seen by psychiatry.</p> <p>Further review of Resident R46's clinical record revealed the facility failed to develop a person-centered care plan related to the resident's thoughts of suicide.</p> <p>Review of the admission sheet dated February 7, 2023, of Resident 48, revealed diagnoses including Dementia (Dementia is not a specific disease but is rather a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities; it is a progressive disease that destroys memory and other important mental functions).</p> <p>Review of Minimum Data Set assessment (MDS- an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) dated May 7, 2024, revealed that Resident R48 had active diagnoses of Non Alzheimer's Dementia.</p> <p>Review of MDS revealed that Resident R 48 received Antipsychotic (Antipsychotic medications have the effect of changing a person's behavior, mood, and emotions), and Anti-Depressant Medications (Antidepressant medications help relieve symptoms of depression, and anxiety disorders).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On May 15, 2024, at 2:14 p.m., review of Resident 48's interdisciplinary plan of care revealed no care plan with measurable goals and interventions to address the care and treatment need related with dementia care of Resident R48.</p> <p>During an interview on May 15, 2024, at 2:243 p.m., the Director of Nursing (DON), confirmed the finding, and the DON stated that the facility tried to make the care plans as specific as possible. No additional information was received.</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</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>47975</p> <p>Based on observations and interviews with residents and staff it was determined the facility did not ensure physicians order were followed related to medication administration and care to a pleurax catheter for two of 21 residents reviewed. (Residents R326 and R329)</p> <p>Findings Include:</p> <p>During Resident Council held on May 15, 2024 at 2:00 p.m. Resident R326 stated during medication administration this morning, she dropped a pill, told the nurse, the nurse did not come back with a replacement pill, and she still hadn't gotten it for the day. The resident was asked by the surveyor if she knew what pill it was and she stated, No, but I have it still I saved it in my room</p> <p>At the end of Resident Council, the surveyor approached licensed nurse, Employee E5 and stated what Resident R326 had said during Resident Council. The surveyor went into Resident R326's accompany by licensed nurse, Employee E5. Observation of resident's room on May 15, 2024 at 2:40 p.m. with Licensed nurse, Employee E5 revealed a purple and orange pill sitting on the resident bed-side tray table.</p> <p>Licensed nurse, Employee E5 obtained the pill and confirmed at the medication cart on the unit that it was the resident's Acebutolol HCl Oral Capsule 200 milligrams. The physican order for the medication was give 1 capsule by mouth every 12 hours related to essential primary Hypertension.</p> <p>Review of Resident 329's nursing progress note dated May 5, 2024 at 9:58 p.m. stated, 80 y/o male admitted to facility from . hospital by ambulance via stretcher x 2 assist. Resident AOX3 (alert and oriented to person, time and place). Incontinent to B&B (bowel and bladder) . Pleurx catheter present to RUQ (right upper quadrant) abdomen, spouse stated she will come and drain catheter every other day .</p> <p>Nursing progress note from May 9, 2024 at 9:18 a.m. stated, as per resident R/P (responsible/party) she will empty his pleurax catheter which is done every other day, MD (physician) made aware, plan of care updated, nursing will continue to monitor him.</p> <p>Nursing note from May 10, 2024 at 1:59 p.m. stated Resident refused for this nurse to drain Pleurx Cath, stating that his girlfriend does it, no distress noted at this time.</p> <p>Nursing progress note from May 15, 2024 at 11:53 a.m. stated, Pleurax catheter being drained by girlfriend</p> <p>The Director of Nursing, Employee E2, was interviewed on May 17, 2024 at 9:40 a.m. regarding Resident R329's girlfriend providing nursing care to the resident while in the facility, and was questioned if she had any training from the facility. The Director of Nursing, Employee E2 confirmed that the girlfriend did the Pleurax catheter care draining one time and was then educated on not being able to do it while he was at the facility. The Director of Nursing, Employee E2 confirmed there was no documentation regarding this discussion with the girlfriend.</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.10(c) Resident care policies 28 PA Code 211.12(d)(1)(3) Nursing services

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735</p> <p>Based on on the review of clinical records and facility documentation, observations, interview with residents and staff, it was determined that the facility did not ensure an environment was free of potential hazards related to medications left at bedside, a fall incident, and no railing around the loading dock for three of 30 residents' records reviewed (Rooms R326, R328, R329).</p> <p>Findings include:</p> <p>Review of facility policy named, Safety and Supervision of Residents, initially adapted in 2001, stated; Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .Resident supervision is a core component of the systems approach to safety.</p> <p>On [DATE] at 10:24 a.m. observation was made of Resident R326's room. Observation of the room revealed two medications bedside on the night stand. The medications at bed side included lactase enzyme 375 milligrams (mg) capsules and a bottle of Artificial Tears. Further observation of the lactase enzyme pill bottle revealed an expiration date of [DATE]. Interview with Resident R326 revealed the resident takes them as needed before meals. Resident R326's stated the pills were not expired but rather the new bottle of pills were poured into the old bottle.</p> <p>Interview with licensed nurse Employee E5 on [DATE] at 10:30 a.m. revealed the resident did not have an order for either of these medications and there was no knowledge of the resident having these at bedside. Licensed nurse Employee E5 confirmed at 10:32 a.m. the medications were bedside, and she took them from Resident R326's possession.</p> <p>On [DATE] at 12:05 p.m. observation was made of Resident R328's room. Observation of the room revealed two inhalers located bedside on the resident's tray table. The inhalers included a Dulera inhaler and a Spiriva inhaler. Interview with the resident revealed the resident was discharged from the hospital on [DATE] and brought the inhalers with her. The resident stated she has been using the Dulera two times a day and the Spiriva one time day since residing at the facility.</p> <p>Interview with licensed nurse Employee E5 on [DATE] at 12:15 p.m. revealed the resident did not have an order for either of these medications and there was no knowledge of the resident having these bedside. Licensed nurse E5 confirmed at 12:18 p.m. the medications were bedside, and she took them from Resident R328's possession.</p> <p>On [DATE] at 11:41 a.m. observation was made of Resident R329's room. Observation of the room revealed a Probiotic pill pack found bedside on the resident's nightstand. A care aide, hired by the resident's girlfriend to provide care while in the facility was in the resident's room and stated that the girlfriend gives the Probiotic pill to the resident once daily.</p> <p>Interview with licensed nurse, Employee E5 on [DATE] at 11:45 a.m. revealed the resident did not have an order for the pills and there was no knowledge of the resident having these bedside. Licensed nurse Employee E5 confirmed at 11:48 a.m. the medication was bedside, and she took them from Resident R329's possession.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.18(b)(1) Management 28 Pa Code 211.10(d) Resident care policies 28 Pa Code 211.12(c) Nursing services 28 Pa Code 211.12(d)(1) Nursing services 28 Pa Code 211.12(d)(5) Nursing services

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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>36609</p> <p>Based on observations, review of facility policy, review of clinical records, and interviews with staff it was determined that the facility failed to monitor a resident's needs to maintain acceptable parameters of nutritional status for one of 21 residents reviewed for nutritional status. (Resident R13).</p> <p>Findings Include:</p> <p>Review of the facilities policy titled, Weight Assessment and Intervention with a revision dated on March 2022 state, Resident weights are monitored for undesirable and unintended weight loss or gain.</p> <p>Review of Resident R13's clinical record revealed the diagnoses of muscle wasting and atrophy, hyperlipidemia, hypothyroidism, diverticulitis of large intestine without perforation or abscess without bleeding, unspecified hearing loss, abnormalities of gait and mobility, dysphagia, and cognitive communication deficit.</p> <p>Review of Resident R13's clinical record revealed that the resident was to receive feeding assistance of 1:1 at all meals.</p> <p>Review of Resident R13's hospital discharge records from April 3, 2024 revealed the resident has a weight recorded on April 4, 2024 of 162 pounds.</p> <p>Review of Resident R13's clinical record revealed that the and the resident had a significant weight loss over a period of a month. On April 10, 2024 Resident R13 had a weight of 162.8 pounds. A week later the resident was weighed and her weight was 142.8 pounds. This weight was labeled as incorrect and the resident was re-weighed on April 18, 2024. On April 18, 2024 the resident's weight was 134.4 pounds. The resident was then weighed on April 27, 2024 and she weighed 134.0 pounds. A weight was then taken on May 2, 2024 and then resident weighed 133.4 pounds. The resident was then weighed on May 13, 2024 and the resident's weight was 136.8 pounds.</p> <p>Observation made on May 15, 2024 at 12:37 p.m. revealed the resident was in her room with her sister. The surveyor asked if her lunch was satisfactory and the resident's sister stated, she took one or two bites, she does better with things like sandwiches. The resident's sister asked for a peanut butter and jelly sandwich.</p> <p>Review of Nutrition note completed on May 1, 2024 states, The husband mentioned in the care conference that the resident has the tendency to pocket foods and prefers to drink liquids with a straw, more finger foods and sandwiches are preferred by the resident. Preferences updated.</p> <p>Observation was made during the lunch meal on May 15, 2024 the resident was not receiving finger foods. The resident was not receiving sandwiches as preferred. No documentation regarding preferences was made in the resident's clinical record.</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>Review of the resident's clinical record revealed a nutrition note from May 14, 2024 stating, Resident is at risk for malnutrition r/t (related to): Poor intake, meeting only 30-40% needs. Intervention: Encourage PO (by mouth) intake and supplements; ensure and magic cup, Proving assistance and supervision during meal times, Weekly weights x 4.</p> <p>Weekly weights were ordered to be completed on Wednesdays starting on May 15, 2024. Review of the resident's record on May 16, 2024 revealed there was no weight taken for the resident on May 15, 2024 and there was no documentation of any attempt of refusal to complete weekly weight as ordered.</p> <p>Interview held with the Registered Dietician, Employee E11 on May 16, 2024 confirmed Resident R13 did have a significant weight loss over the period of a month. Employee E11 stated the kitchen would be educated on Resident R13's preferences and need for finger foods during meals.</p> <p>Observation was made of the lunch time meal on May 17, 2024. The lunch cart arrived at 12:29 p.m. Resident R13's meal was brought to her room at 12:35 p.m. Scheduler, Employee E12 and Human Resources Director, Employee E13 went into the resident's room at 12:47 p.m. The surveyor checked in with licensed nurse Employee E5 and 12:50 p.m. and was questioned who would be providing Resident R13 with feeding assistance for lunch. Licensed nurse Employee E5 stated, anyone can, I was about to go in there now. The surveyor and licensed nurse Employee E5 went into the room at 12:51 p.m. and no staff was present in the room. Observation was made of the Resident's tray revealed no meal ticket and baked fish, brussel sprouts, and scalloped potatoes present on the plate. There were still no finger foods served for Resident R13.</p> <p>Interview held at 12:54 p.m. with scheduled Employee E12 and Employee E12 stated, oh no, I fed her. When questioned about Resident R13's feeding and no one being in the room for more than two minutes, Employee E12 stated, oh no I fed her today for breakfast and lunch.</p> <p>Review of unit Nurse Aide Assignment sheet showed Resident R13 was not listed as a feeder on nurse aide Daily Assignment Sheet from 5/17, 5/16, 5/15, 5/14, and 5/13.</p> <p>Review of Resident R13's clinical record revealed the residents percentage of meals eaten over the last thirty days were not recorded for the following dates:</p> <p>April 21, 2024 not recorded for breakfast and lunch.</p> <p>April 22, 2024 not recorded for breakfast and lunch.</p> <p>May 5, 2024 not recorded for dinner.</p> <p>May 12, 2024 not recorded for breakfast or lunch.</p> <p>May 15, 2024 not recorded for dinner.</p> <p>28 Pa. Code 211.10 (c) Resident care policies</p> <p>28 Pa. Code 211.12 (d)(3) Nursing Services</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395690	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024
NAME OF PROVIDER OR SUPPLIER Springfield Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 463 West Sproul Road Springfield, PA 19064	
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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>47975</p> <p>Based on resident council interviews, review of the established meal time schedule, and clinical record review, it was determined that the facility failed to ensure a nourishing snack was provided when in between meals for five of 21 residents reviewed. (Residents R275, R22, R326, R14, and R13).</p> <p>Findings Include:</p> <p>Resident Council was held on May 15, 2024 at 2:00 p.m. When asked if the resident's receive snacks in the evening four out of five residents stated that they have never received a snack in the evening.</p> <p>Review of Resident R275's evening snack record revealed, no snack was given on May 14, 2024.</p> <p>Review of Resident R22's evening snack record revealed, no snack was given on April 20, April 26. May 1, May 2, May 4, May 5, May 14, 2024.</p> <p>Review of Resident R326's evening snack record revealed, no snack was given on May 11, May 14, and May 16, 2024.</p> <p>Review of Resident R14's evening snack record revealed, no snack was given on May 6, May 9, and May 14, 2024.</p> <p>Review was made of Resident R13's clinical record due to the resident having a significant weight loss over the period of a month. Review of Resident R13's evening snack record revealed, no snack given on April 18, April 21, April 22, April 28, May 1, May 13, May 16, 2024.</p> <p>28 Pa. Code 201:14 (a) Responsibility of licensee</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735</p> <p>Based on observations, interviews with staff, and a review of facility policies and documentation, it was determined that the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <p>The Policy: Food Receiving and Storage, which was revised in [DATE], states, All foods stored in the refrigerator or freezer are covered, dated and labeled.</p> <p>An initial tour of the Food Service Department was conducted on [DATE], at 9:30 a.m. with Employee E3, Food Service Director (FSD), which revealed the following:</p> <p>Observation in the mop room revealed the floor and walls were very dirty, the white mop sink was black with a heavy buildup of dirt and grime, and the floor was littered with debris and equipment.</p> <p>Observation in the kitchen near the pot sink revealed the walls were spattered with food particles and the sanitizer mount on the wall had a thick buildup of dirt and dust.</p> <p>Observation in the walk-in freezer revealed a box of breaded veal patties that was open and the inner plastic liner was open to the air.</p> <p>Observation of the oven under the flat-top griddle revealed a heavy buildup of burned-on food spatters in the bottom and sides of the oven.</p> <p>Interview with FSD at 9:45 a.m. on [DATE], confirmed the above findings.</p> <p>Review of facility policy titled, Foods brought in by Family/Visitors undated revealed, Food brought in to the facility by visitors or family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. 5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility prepared food. a. Non-perishable food items are stored in re-sealable containers with tight-fitting lids. Intact fresh fruit may be stored without a lid. b. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. 6. Nursing staff will discard perishable foods on or before the use by date.</p> <p>Observation of the north wing unit on [DATE] at 10:44 a.m. revealed licensed nurse, Employee E5 was at the Resident refrigerator throwing away plastic food containers and labeling food items for residents. The Director of Nursing Employee E2 was present during observation and stated there was a new night shift housekeeping supervisor that just started and would be responsible for evening sweeps of the resident refrigerators.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of the food in refrigerator revealed several expired, unlabeled, and undated items. A bag of Chinese food take-out labeled [DATE]. Two small plastic cups of chocolate pudding undated and unlabeled. Thirteen small milk cartons with an expiration date of [DATE]. A take out bag with a cheeseburger and two apple pies undated and unlabeled. Take out food for a resident labeled with a date of [DATE]. Observation of the refrigerator also revealed human hair and spills throughout the floor and door of the refrigerator.</p> <p>Observation of the resident freezer revealed a milkshake in freezer unlabeled and undated. A drink with a date of [DATE]. Observation revealed human hair and spills in the freezer.</p> <p>Observation of the east wing refrigerator was made on [DATE] at 11:11 a.m. Observation of the food in the refrigerator revealed several expired, unlabeled, and undated items. A large Styrofoam cup with vanilla pudding was labeled [DATE]. There was a small plastic chocolate pudding unlabeled and undated. There was a small plastic red Jello cup unlabeled and undated. There was a bottle of ranch dressing with an expiration of [DATE]. There was a yellow mustard bottle with an expiration date on [DATE]. A yogurt cup with an expiration date of [DATE]. The refrigerator had food spills both in the bottom and in the door.</p> <p>Review of the freezer revealed liquid spills on the bottom of the freezer. A cup of half-eaten ice cream for a resident unlabeled and undated. Two blue 'Gatorade' frozen unlabeled and undated.</p> <p>Further observations of the kitchenettes again [DATE] at 10:10 a.m. revealed expired mustard still present in the refrigerator. There was chicken and rice take out unlabeled and undated. There was slice of pizza in between two plates unlabeled and unlabeled.</p> <p>28 Pa Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(3) Management</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>38735</p> <p>Based on observations and an interview with staff, it was determined that the facility did not ensure that garbage and refuse was disposed of properly.</p> <p>Finding include:</p> <p>An initial tour of the Food Service Department was conducted on May 14, 2024, at 9:30 a.m. with Employee E3, Food Service Director (FSD), which revealed the following:</p> <p>Observation in the receiving area revealed one of three dumpsters with the lid open revealing the contents including cardboard boxes.</p> <p>Further observations revealed that the employee smoking area was adjacent to the loading dock and that the ground all around the loading dock was littered with hundreds of cigarette butts.</p> <p>Interview with the FSD on May 14, 2024, at 9:35 a.m. confirmed the above findings.</p> <p>28 Pa. Code 201.18(b)(3) Management</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</p>

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735</p> <p>Based on a review of facility documents and resident clinical records and interviews with staff and residents, it was determined that the facility failed to ensure that residents had the capacity to understand the terms of a binding arbitration agreement for three of nine residents reviewed (Resident R226, R227 and Resident R228).</p> <p>Findings include:</p> <p>Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:</p> <p>13-15: cognitively intact</p> <p>8-12: moderately impaired</p> <p>0-7: severe impairment</p> <p>Review of admission record indicated Resident R226 was admitted to the facility on [DATE].</p> <p>Review of Resident R226's Minimum Data Set (MDS - a periodic assessment of care needs) dated March 17, 2024, indicated the diagnoses of fracture and orthopedic aftercare and a BIMS score of 3 - severe impairment of cognition.</p> <p>Review of Resident R226's Binding Arbitration Agreement (a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) indicated that she signed the document on admission on February 24, 2023.</p> <p>Review of admission record indicated Resident R227 admitted to the facility on [DATE].</p> <p>Review of R227's MDS dated [DATE], indicated the diagnoses of aphagia (comprehension and communication (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain) and a BIMS score of 3 - severe impairment of cognition.</p> <p>Review of Resident R227's Binding Arbitration Agreement indicated she signed it on admission on May 23, 2022.</p> <p>Review of admission record indicated Resident R228 admitted to the facility on [DATE].</p> <p>Review of R228's MDS dated [DATE], indicated the diagnoses of cerebral infarction (or stroke, is a brain lesion in which a cluster of brain cells die when they don't get enough blood) and a BIMS score of 6 - severe impairment of cognition.</p> <p>(continued on next page)</p>

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R228's Binding Arbitration Agreement indicated he signed it on admission on February 13, 2024.</p> <p>Interview on May 16, 2024, at 2:05 p.m. with the Nursing Home Administrator confirmed that these three residents had a low BIMS score, indicating severe cognitive impairment, and should not have been signing admissions documents including the binding arbitration agreement as they did not have the capacity to understand the terms of a binding arbitration agreement.</p> <p>28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(e)(1) Management</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343</p> <p>Based on observation, review of facility policy and procedure, and interviews with staff, it was determined that the facility failed to maintain an effective infection control program, related with linen transportation, and personal protective equipment disposal for one of one resident observed during tracheotomy care. (Resident R56).</p> <p>Findings include:</p> <p>Observation on May 15, 2024, at 11:33 a.m., revealed that a Nurse Aide, Employee E15, was taking clean linen from the Linen Storeroom, located adjacent to Resident room [ROOM NUMBER], was holding the clean linen letting it to touch the Nurse Aide's uniform of her upper body area, and was carrying the linen the same manner, up to Resident room [ROOM NUMBER], located in the other nursing unit, for the use of residents.</p> <p>At the time of the finding, interviewed with nurse aide, Employee E15, and confirmed that the linen should have been transported without letting it touch the employee's clothing, to prevent contamination and to maintain infection control.</p> <p>Observation on May 16, 2024, at 1:41 p.m., revealed that a Licensed Practical Nurse (LPN) , Employee E16, after administering the tracheostomy care to Resident R56, of room [ROOM NUMBER]-B, who was on Enhanced Barrier Precautions, threw E16's used gown on the floor of Resident 12's door side, where the bed of the roommate (R12-A) was placed; since E16 could not find a trash bin to dispose the gown, used while treating Resident R56, the resident who was on Enhanced Barrier Precautions.</p> <p>At the time of the finding, interviewed E16, and confirmed that the used gown should have been disposed, not on the floor, but in a container, dedicated for the disposal of used Personal Protective Equipment (PPE), in the room itself, of the resident, who was on Enhanced Barrier Precautions, to prevent contamination and to maintain infection control.</p> <p>28 Pa Code 211.12 (d)(1)(5) Nursing services</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>39343</p> <p>Based on observation and staff interview, it was determined that the facility failed to ensure that the loading dock was in safe conditions.</p> <p>Findings include:</p> <p>Observations during the tour of the kitchen on May 14, at 9:30 a.m. revealed a loading dock door that was open leading to the receiving area where there was a wooden loading dock structure that was five feet off the ground with no railing or chain to restrict access and provide safety for staff, delivery drivers and anyone who may exit the rear door including wandering residents.</p> <p>Interview with Food Service Director, Employee E3, on May 14, at 9:30 a.m. confirmed that the loading dock door was open due to receiving a delivery that morning, and that the loading dock structure does not have any safety railing and that Dietary staff receive deliveries there daily. The FSD indicated that while this is an employee only area, residents have entered the hallway leading to the receiving area to come to the kitchen and that if no one was in the area and the receiving door was open, they could wander out to the loading dock and fall.</p> <p>Interview with the Administrator on May 16, 2024, at 11:00 a.m. confirmed that there is no safety railing around the loading dock.</p> <p>28 Pa Code: 201.14(b) Responsibility of licensee</p>		