

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395710	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Oxford Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 East Winchester Ave Langhorne, PA 19047	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>45125</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident and the resident's representative(s) of transfer(s), including the reasons for the moves and Ombudsman information, in writing upon transfer from the facility for three of five sampled residents who were transferred to the hospital. (Residents 123, 139, and 142)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 123 was transferred to the hospital on July 30, 2024, and on September 9, 2024 after a change in condition. There was no documentation to support that the resident and/or the resident's responsible party or legal representative were provided written information regarding the transfers to the hospital.</p> <p>Clinical record review revealed that Resident 139 was transferred to the hospital on October 21, 2024, after a change in condition. There was no documentation to support that the resident and/or the resident's responsible party or legal representative were provided written information regarding the transfer to the hospital.</p> <p>Clinical record review revealed that Resident 142 was transferred to the hospital on October 10, 2024, after a change in condition. There was no documentation to support that the resident and/or the resident's responsible party or legal representative were provided written information regarding the transfer to the hospital.</p> <p>In an interview on November 15, 2024, at 2:00 p.m., the Administrator confirmed that written notifications of transfers were not provided for these residents.</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 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** 45125</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan to meet each resident's needs identified in the comprehensive assessment for two of 36 sampled residents. (Residents 61 and 65)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 61 was admitted to the facility on [DATE], and had a diagnoses that included dementia. The Minimum Data Set Care Area Assessment summary dated July 21, 2024, noted that the resident's cognitive decline/dementia was to be addressed in the care plan. There was no evidence that interventions to address Resident 61's cognitive decline/dementia were included in the current care plan.</p> <p>Clinical record review revealed that Resident 65 was admitted to the facility on [DATE], and had a diagnoses that included dementia. The Minimum Data Set Care Area Assessment summary dated October 11, 2024, noted that the resident's cognitive decline/dementia was to be addressed in the care plan. There was no evidence that interventions to address Resident 65's cognitive decline/dementia were included in the current care plan.</p> <p>In an interview on November 15, 2024, at 10:45 a.m., the Director of Nursing confirmed there was no documented evidence that the identified care area was addressed in Residents 61 and 65's current care plans.</p> <p>28 Pa. Code 211.12(d)(1)(5)Nursing services.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>43883</p> <p>Based on facility policy review, clinical record review, observation, and resident, staff, and family interview, it was determined that the facility failed to provide services to maintain adequate grooming and hygiene for four of five sampled residents who required assistance with activities of daily living (ADLs). (Residents 5, 27, 28, and 81)</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Activities of Daily Living, last reviewed, April 3, 2024, revealed that residents who were unable to carry out ADLs independently would receive the services necessary to maintain good grooming and personal hygiene.</p> <p>Clinical record review revealed that Resident 5 had diagnoses that included depression, osteoarthritis, and muscle wasting. Review of the care plan revealed that the resident required assistance from staff for ADLs. On November 13, 2024, at 12:18 p.m., the resident was observed in bed. Her fingernails were long and dirty with a substance underneath the nails. She stated that she preferred her nails to be kept short, her nails needed to be cut, staff had not offered to cut her nails, and she had not refused. There were no documented refusals.</p> <p>Clinical record review revealed that Resident 27 had diagnoses that included adult failure to thrive and muscle wasting. Review of the care plan revealed that the resident required assistance from staff with ADLs. The intervention was for staff to check nail length; clean and trim as needed on bath days. On November 13, 2024, at 12:26 p.m., the resident was observed out of bed to her wheelchair. Her nails were observed to be long and discolored. The resident stated she preferred her nails to be kept short. On November 14, 2024, at 12:00 p.m., the resident was again observed out of bed to her wheelchair; her nails remained long and discolored. In a phone interview on November 14, 2024, at 9:48 a.m., the resident's representative stated the resident's nails were not being cut regularly. There were no documented refusals.</p> <p>Clinical record review revealed that Resident 81 had diagnoses of hemiplegia to the right side, and vertical strabismus (a condition in which the eyes are not aligned). Review of the care plan revealed that the resident required assistance from staff for ADLs. The intervention was for staff to check nail length; clean and trim on bath days. On November 13, 2024, at 12:35 p.m., the resident was observed out of bed to his wheelchair. The nails on his right hand were long and discolored. He stated that he preferred his nails to be short, staff had not offered to cut his nails on that hand, and he had not refused.</p> <p>In an interview on November 15, 2024, at 9:03 a.m., the Director of Nursing (DON) stated that the residents' nails required care and nail care should have been provided with bathing and as needed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Clinical record review revealed that Resident 28 had diagnoses that included depression and anxiety. Review of the care plan revealed that the resident required assistance from staff for ADLs. On November 12, 2024, at 12:52 p.m., the resident was observed in bed. Her hair appeared disheveled and unkempt. She stated that her hair needed to be washed and combed, staff did not offer assistance to comb or wash her hair when she was bathed, and she had a large knot of hair on the back of her head. On November 13, 2024, at 10:23 a.m., the resident was again observed in bed. Her hair remained disheveled and unkempt; there was a large matted area of hair on the back of her head. She stated that staff had still not offered assistance with combing her hair. There was no evidence of refusals.</p> <p>In an interview on November 15, 2024, at 9:03 a.m., the DON stated that the resident's hair required combing and staff should have offered assistance to wash or comb her hair.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>45125</p> <p>Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure physician's orders were implemented for five of 36 sampled residents. (Residents 24, 34, 65, 95, and 145)</p> <p>Findings include:</p> <p>Review of the policy entitled, Administering Medications, last reviewed April 3, 2024, revealed that staff were to obtain vital signs if necessary, and document physician indicated medication administration information.</p> <p>Clinical record review revealed that Resident 24 had diagnoses that included heart failure and chronic obstructive pulmonary disease. On November 8, 2024, the physician ordered for staff to obtain a daily weight for the resident. A review of Resident 24's weights revealed that there was no documented evidence that a weight was obtained on November 8, 9, and 10, 2024.</p> <p>Clinical record review revealed that Resident 34 had diagnoses that included dysphagia (difficulty swallowing) and chronic obstructive pulmonary disease. On September 28, 2022, the physician ordered for staff to obtain a weekly weight for the resident. A review of Resident 34's October and November 2024 weights revealed there was a lack of documentation to support that weekly weights were completed five of seven times.</p> <p>Clinical record review revealed that Resident 65 had diagnoses that included hypertension (high blood pressure). On June 1, 2024, the physician ordered staff to administer a blood pressure medicine (lisinopril) once a day. Staff were not to administer the medication if the resident's systolic blood pressure (the first measurement of blood pressure when the heart beats and the pressure is at its highest) was less than 110 millimeters of mercury (mm Hg). Review of Resident 65's October and November 2024 Medication Administration Records (MAR) revealed that staff administered the medication 45 times with no documentation that the blood pressure was assessed prior to medication administration per physician's order.</p> <p>Clinical record review revealed that Resident 95 had diagnoses that included heart failure and diabetes. On October 10 and 11, 2024, the physician ordered staff to administer a blood pressure medicine (carvedilol) twice a day. Staff were not to administer the medication if the resident's systolic blood pressure was less than 100 mm Hg or if the resident's heart rate was below 60 beats per minute. Review of Resident 95's October and November 2024 MARs revealed that staff administered the medication 42 times with no documentation that the blood pressure and heart rate were assessed prior to medication administration per physician's order.</p> <p>Clinical record review revealed Resident 145 had diagnoses that included dependent edema. On November 1, 2024, the physician ordered that staff obtain a daily weight for the resident. A review of Resident 145's weights revealed that there was no documented evidence to support a weight was obtained on November 2, 3, and 5 through 13, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on November 15, 2024, at 12:15 p.m., the Administrator confirmed there was no documentation to support that weights were obtained by staff or refused by the residents on the previously mentioned dates for Residents 24, 34, and 145.</p> <p>In interviews on November 15, 2024, at 10:30 a.m. and 12:53 p.m., the Director of Nursing and Administrator confirmed there was no documented evidence that the blood pressure and heart rate were taken prior to medication administration per physician's order for Residents 65 and 95.</p> <p>CFR 483.25 Quality of Care</p> <p>Previously cited 12/12/23</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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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>43883</p> <p>Based on review of the facility meal schedule, observation, and resident interview, it was determined that the facility failed to ensure that meals were served at regularly scheduled times in accordance with resident needs on one of three nursing units. (Third floor)</p> <p>Findings include:</p> <p>Review of the facility's meal schedule revealed that the second and final meal cart delivery for the third-floor nursing unit was for 12:45 p.m.</p> <p>During a group interview on November 13, 2024, at 10:37 a.m., Resident 51 stated that the meals were often served late.</p> <p>Observation on November 13, 2024, revealed the second meal cart arrived to the third-floor nursing unit at 1:10 p.m., and tray pass began at 1:20 p.m., 35 minutes after the scheduled meal time. Observation of the meal cart at 1:28 p.m., revealed that the cart was empty and all trays had been delivered. At that time, Residents 33, 37, 74, 107, 119, and 139, had not received a meal tray. At 1:35 p.m., Resident 119 stated he did not yet receive a meal tray. At 1:37 p.m., Resident 37 stated that his meal tray was frequently missing from the meal cart.</p> <p>In an interview at 1:30 p.m., Nurse Aide 1 confirmed that the residents' meal trays did not arrive on the meal cart as scheduled.</p> <p>Observation at 1:47 p.m., revealed that meal trays were delivered to Residents 37, 107, 119, and 139, over one hour after the scheduled meal time. Residents 33 and 74 had not yet received a meal tray. In an interview at 1:55 p.m., Licensed Practical Nurse 1 confirmed that Resident's 33 and 74 had not yet received a meal tray.</p> <p>Observation at 2:06 p.m., revealed that meal trays were delivered to Residents 33 and 74, over 80 minutes after the scheduled meal time.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p>		