STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395721	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paramount Nursing and Rehab at Fayetteville, LLC	6375 Chambersburg Road Fayetteville, PA 17222

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46253 Based on observations and staff interviews, it was determined that the facility failed to maintain a safe, clean, and home-like environment for two of 20 residents observed (Residents 35 and 54). Findings include: Observations of Resident 35's room on July 1, 2024, at 9:59 AM, and July 2, 2024, at 11:51 AM, revealed a pedestal fan with gray fuzzy debris on the blades and blowing from the front of the fan. Observations of Resident 54's room on July 1, 2024, at 11:18 AM, and July 2, 2024, at 11:52 AM, revealed a small fan sitting on a nightstand with gray fuzzy debris on the blades and blowing from the front of the fan. In an email communication received from the Nursing Home Administrator (NHA) on July 3, 2024, at 9:08 AM, the NHA revealed that the facility did not have a policy on the cleaning of fans. She further indicated that she had spoken to the housekeeping manager and that the cleaning of fans had now been added to the monthly resident room deep clean list. She also indicated that the housekeeping staff had cleaned all facility fans. In an interview with the NHA on July 3, 2024, at 10:54 AM, the NHA indicated that housekeeping staff was wiping down the outside of the fans and confirmed that they had no process for disassembling the fans and cleaning the blades of any debris before July 2, 2024. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management.

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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48484 Based on observations, clinical record review, and staff interviews, it was determined that the facility failed to provide care and services to promote healing and prevent worsening of pressure ulcers for one of two residents reviewed for pressure ulcers (Resident 56). Findings include: Review of Resident 56's clinical record revealed diagnoses that included stage 4 pressure ulcer of the right heel (wound that occurs when the skin and tissue are damaged by prolonged pressure), type 2 diabetes mellitus with foot ulcer (a metabolic disorder in which the body has high sugar levels for prolonged periods of time leading to breakdown of skin and sometimes deeper tissues), and hypertension (high blood pressure). Review of Resident 56's physician orders revealed an order for Heels up when in bed, with a start date of March 29, 2024. Further review of Resident 56's physician orders revealed an order for Offloading boot to be worn in bed to RLE (right lower extremity), with a start date of April 2, 2024. Review of Resident 56's weekly wound consultation notes revealed recommendations from the wound physician initiated April 8, 2024, for Float heels while in bed, limit sitting for 60 minutes, bed cradle to keep weight of blankets off toes, elevate legs. Further review of all weekly wound consultation notes from April 8, 2024, to present revealed The clinical documentation for this consultation was made available to the referring physician. This documentation has also been made available for access to the appropriate personnel and placement in the medical record. Observations of Resident 56 in her room on July 1, 2024, at 10:35 AM, 11:18 AM, and 12:22 PM, revealed both of her feet were exposed and laying directly on her mattress. During an interview with the Director of Nursing (DON) on July 2, 2024, at 1:56 PM, the surveyor revealed the observations of Resident 56 in bed without elevated heels, no offloading boot to RLE, and no bed cradle. During a follow-up interview with the DON on July 3, 2024, at 12:59 PM, he revealed the bed cradle was implemented that morning. He further revealed the process for communicating wound physician recommendations is the facility wound nurse will communicate any recommendations from the wound physician to the facility physician to review and order, unless he disagrees. Further, he could not find any documentation to indicate the physician disagreed with the weekly recommendation for the bed cradle, dating back to April 8, 2024. During an interview with the Nursing Home Administrator on July 3, 2024, at 1:01 PM, she revealed she was unable to locate documentation to indicate Resident 56 had refused her heels up or offloading boot at the time of surveyor observations. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 46253 Based on observations, clinical record review, and staff interviews, it was determined that the facility failed to ensure a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one of three residents reviewed (Resident 54). Findings include: Review of Resident 54's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and muscle weakness. Review of Resident 54's physician orders revealed an order for a palm protector to the right hand due to contracture (condition of shortening and hardening of muscles, tendons, or other tissue often leading to deformity and rigidity of joints), may remove for care, dated May 21, 2024. Observation of Resident 54 and their room on July 1, 2024, at 11:18 AM, revealed Resident 54's palm protector was lying on a chair in their room and that Resident 54 was in an activity with no palm protector in place. Observation of Resident 54 on July 1, 2024, at 12:46 PM, revealed that they were seated in the common area near the nurse's station with no palm protector in place. Review of Resident 54's Treatment Administration Record for May 2024, June 2024, and July 2024, failed to reveal any documentation of the application of their ordered palm protector. In an email communication received from the Nursing Home Administrator (NHA) on July 3, 2024, at 12:19 PM, the NHA indicated that they had no documentation to provide for Resident 54's palm protector application/usage since ordered on May 21, 2024. She further indicated that the facility considers a palm protector to be a splint. In an interview with the NHA and the Director of Nursing on July 3, 2024, at 12:50 PM, the NHA confirmed that staff should have been documenting the application and/or refusal of the palm protector. 28 Pa. Code 211.10(d) Resident Care Policies 28 Pa. Code 211.12(d)(5) Nursing Services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48484 Based on facility policy review, observations, clinical record review, and staff interviews, it was determined that the facility failed to monitor hydration status precisely and effectively for one of 20 residents reviewed (Resident 19). Findings include: Review of facility policy, titled Fluid Restriction Policy, last revised February 12, 2022, read, in part, Purpose: To ensure that fluid restricted residents receive adequate hydration by close monitoring .Care Plans will be updated to address interventions. Review of Resident 19's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included congestive heart failure (CHF - long-term condition that happens when your heart can't pump blood well enough to meet your body's needs), shortness of breath (uncomfortable feeling of not being able to breathe well enough), and acute upper respiratory infection. Review of Resident 19's physician orders revealed an order: Regular diet, Regular texture, Thin consistency (fluids), Fluid Restriction 2000ml (milliliter- unit of measure), with a start date of February 4, 2024. Further review of resident 19's clinical record failed to reveal notation in her care plan about her fluid restriction, or a breakdown of fluids provided between dietary and nursing each shift. Observation in Resident 19's room on July 1, 2024, at 11:20 AM, revealed a large cup on her bedside table containing approximately 120 ml of water. Review of Resident 19's dietary tray tickets from July 1, 2024, revealed she was provided 1560 ml of fluid from dietary throughout the day: 360 ml at breakfast, 720 ml at lunch, and 480 ml at dinner. Review of nurse aide task, titled Additional Fluids on July 1, 2024, revealed Resident 19 was documented as receiving 120 ml at 5:35 AM; 480 ml at 1:02 PM; 60 ml at 6:12 PM; and 120 ml at 10:47 PM. Review of nurse aide task, titled Fluids on July 1, 2024, revealed Resident 19 was documented as receiving 240 ml of fluid at 1:01 PM, 1:25 PM, 6:12 PM, and 9:59 PM. Observation in Resident 19's room on July 2, 2024, at 10:07 AM, revealed a large cup on her bedside table containing approximately 480 ml of water. Email correspondence with the Nursing Home Administrator on July 2, 2024, at 2:24 PM, the surveyor questioned the two different nurse tasks capturing fluids as well as how the facility is managing Resident 19's fluid restriction. Observation in Resident 19's room on July 3, 2024, at 09:41 AM, revealed a large cup on her bedside table containing approximately 120 ml of water. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nurse aide task, titled Additional Fluids on July 3, 2024, revealed Resident 19 was documented as receiving 480 ml at 9:56 AM by Employee 1 (Nurse Aide). Review of nurse aide task, titled Fluids on July 3, 2024, revealed Resident 19 was documented as receiving 240 ml of fluid at 9:56 AM by Employee 1. During an interview with Employee 1 on July 3, 2024, at 10:31 AM, he revealed he was unaware Resident 19 was on a fluid restriction, and that he does not provide additional fluids to Resident 19, he only documents what is provided from dietary. During an interview with the Director of Nursing (DON) on July 3, 2024, at 10:59 AM, he revealed nurse aides document the fluids from dietary under fluids, and fluids provided by nursing, including fluids provided during medication pass, under additional fluids. Further, the DON stated that Employee 1 might not know about Resident 19's fluid restriction as he is a fairly new employee. During a follow up interview with the DON on July 3, 2024, at 1:18 PM, the surveyor revealed the concern with the overall management and monitoring of Resident 19's fluid restriction. No further information was provided. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 46253 Based on policy review, observations, clinical record reviews, and resident and staff interviews, it was determined that the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice related to intravenous (IV - tube inserted into a vein, which medication is administered through) therapy for two of two residents receiving IV medications (Residents 64 and 326). Findings Include: Facility policy, titled 13.6 Medication Administration Guidelines: Specific, effective date October 1, 2018, stated in part, 7. Compare the MAR (medication administration record) with the medication label for accuracy and note the following: A. Incorrect label or direction change by the health care provider .D. If the label and MAR differ for any other reason or if there are questions about the dosage or directions, do not administer the medication. Contact pharmacy provider. Review of Resident 64's clinical record revealed diagnoses that included osteomyelitis (infection of a bone) of the lumbar (lower back) region and discitis (an infection of the intervertebral disc, a structure that separates the vertebrae in the spine). Review of Resident 64's current physician orders revealed an order for Meropenem intravenous (IV) solution reconstituted administer one gram intravenously three times a day related to osteomyelitis of vertebra, dated June 17, 2024. During an interview with Resident 64 on July 1, 2024, at 9:53 AM, it was observed that an empty medication solution bag of Meropenem was hanging on an IV pole, the IV tubing was not dated, and the end of the IV tubing was secured into a port on the IV tubing. Observation also revealed a sheet of IV line end caps to be present hanging on the intravenous pole near the empty medication solution bag. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on July 3, 2024, at 10:55 AM, the DON confirmed that Resident 64's IV tubing should have been properly dated and capped. Review of Resident 326's clinical record revealed diagnoses that included: bacteremia (bacteria in the blood) and excoriation disorder (a mental illness related to obsessive-compulsive disorder characterized by repeated picking at the skin). Review of Resident 326's physician orders revealed an order for daptomycin 500 mg intravenously one time a day for infection. Review of Resident 326's medication administration record for July revealed daptomycin 500 mg documented as administered at 5:00 AM on July 1, 2024. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the initial tour of the facility on July 1, 2024 at 10:44 AM, an observation of Resident 326 was completed, which revealed an IV medication bag hanging on an IV pole at Resident 326's bedside. At the time of the observation, Resident 326 revealed that she had an infection and had received IV antibiotics earlier that morning. Further observation of the IV setup revealed an IV medication bag with a pharmacy label showing daptomycin (antibiotic medication) 500 milligrams (mg) per 100 milliliters (ml) of normal sterile saline with another resident's name on the label, the IV tubing end was connected into one of the ports on the tubing, and no date was observed on the tubing. During a staff interview on July 1, 2024 at 10:56 AM, with Employee 3 (Licensed Practical Nurse), it was revealed that the night shift registered nurse was responsible for hanging IV medications. During an additional staff interview on July 1, 2024 at 11:00 AM, with Employee 2 (Registered Nurse Supervisor), it was revealed that the bag of IV medication was the correct medication, but was for another resident. Employee 2 stated the IV tubing should have been dated and that the tubing should have been capped, not connected to itself. Employee 2 removed the IV medication bag and tubing from Resident 326's room. During a staff interview on July 3, 2024, with the NHA and the DON, the DON revealed it was the expectation of the facility that residents be free from medication errors, IV tubing be dated, and IV tubing be capped when not in use. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48484 Based on facility policy review, observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to maintain oxygen equipment in a sanitary manner and provide respiratory care consistent will professional standards for one of 20 residents reviewed for oxygen (Resident 19). Findings include: Review of facility policy, titled Oxygen Therapy Policy, last revised April 4, 2018, read, in part, Oxygen tubing will be dated and changed bi-weekly by the 11-7 Licensed Staff. Review of Resident 19's clinical record revealed diagnoses that included Covid-19 (respiratory virus), shortness of breath (uncomfortable feeling of not being able to breathe well enough), and muscle weakness. Observation of Resident 19's oxygen tubing on July 1, 2024, at 11:20 AM, revealed her oxygen tubing was dated June 2, 2024. Observation of Resident 19's oxygen tubing on July 2, 2024, at 10:07 AM, revealed her oxygen tubing was dated June 2, 2024. Review of Resident 19's clinical record revealed she tested positive for Covid-19 infection on June 20, 2024. During an interview with the Director of Nursing (DON) on July 2, 2024, at 10:42 AM, the surveyor revealed the observations of Resident 19's oxygen tubing dated June 2, 2024. Follow-up interview with the DON on July 2, 2024, at 1:56 PM, he revealed the tubing was not changed bi-weekly since June 2, 2024, due to the Resident being asleep and refused when awakened. The surveyor inquired if staff reapproached at a later time or documented the refusals. Observation of Resident 19's oxygen tubing on July 3, 2024, at 9:41 AM, revealed her oxygen tubing was dated July 1, 2024. Interview with Resident 19 on July 3, 2024, at 9:42 AM, revealed the nursing staff came in and changed her oxygen tubing the previous afternoon. Interview with the DON on July 3, 2024, at 10:59 AM, revealed he would expect staff to reapproach about tubing change, document refusal of the tubing change, and that they would follow-up about the wrong date on the new tubing as it was changed on July 2, 2024. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46253 Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two of four residents reviewed (Residents 52 and 326). Findings include: Review of facility policy, titled Isolation Precaution Policy, with a last revised date of July 25, 2023, and a last reviewed date of January 25, 2024, revealed, in part, 1. This facility will follow CDC (Center for Disease Control) guidelines when determining what form of isolation precautions will be instituted i.e., Contact, Respiratory, or Enhanced Barrier Precautions; 2) Isolation precautions will be initiated by a physician's order and or deemed necessary by nursing judgment; and 5) A sign will be placed on the resident's door to alert staff and visitors. Review of facility policy, titled Shingles, with a last revised date of June 20, 2017, and a last reviewed date of January 25, 2024, defined shingles as a painful blistering skin rash due to the varicella-zoster virus, the virus that causes chickenpox; and that the virus will be prevented from transmission to residents and employees within the facility. Review of facility policy, titled Infection Control Enhanced Barrier Precaution Paramount Skilled Nursing and Rehabilitation Facilities, last revised April 1, 2024, revealed Policy Statement - All employees will utilize Enhanced Barrier Precaution for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Implementation 1. For Enhanced Barrier Precautions, signage should clearly indicate the high-contact resident care activities that require use of gown and gloves. 2. Make PPE (personal protective equipment), including gowns and gloves, available immediately outside of the resident room. Review of the Center for Disease Control 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, with a last revised date of September 2018, revealed that Contact Precautions are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment; that Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission; and that someone diagnosed with shingles should remain under contact precautions until lesions are dry and crusted. Review of Resident 52's clinical record revealed diagnoses that included herpes zoster (shingles) and mild cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 52's current physician orders revealed an order for Acyclovir Oral Tablet 400 MG (an antiviral medication used to treat shingles) give one tablet by mouth three times a day related to herpes zoster for 10 days, dated June 24, 2024, and end date of July 4, 2024. The physician orders failed to reveal any orders regarding contact precautions. Further review of Resident 52's past physician orders history revealed that Resident 52 was originally ordered the Acyclovir and contact precautions on June 14, 2024, for 10 days. Observation of Resident of Resident 52's room on July 1, 2024, at 11:56 AM, revealed the presence of a sign that said to see the nurse before entering the room. Immediate interview with a staff nurse revealed that Resident 52 had a diagnosis of shingles and that the Resident was on contact precautions. Observation of Resident 52's room on July 1, 2024, at 12:40 PM, revealed that the aforementioned sign had been removed. Observation of Resident 52's room on July 2, 2024, at 9:47 AM, again revealed no sign was present regarding isolation precautions. Review of Resident 52's clinical record progress notes failed to reveal any nurse's notes between June 28, 2024, and July 2, 2024, that described Resident 52's shingles rash. Review of nurse's note dated July 2, 2024, at 3:00 PM, indicated Acyclovir continues for shingles rash. C/O (complaint of) pain in area with relief noted after Tylenol. Review of order note dated July 2, 2024, at 4:33 PM, indicated Resident 52's physician had followed up with resident at this time for evaluation of shingles as resident now has peripheral edema left upper thigh, and that a new order was given to restart contact isolation for shingles rash for 10 days. During an interview with the Director of Nursing (DON) on July 3, 2024, at 9:44 AM, the DON indicated that the staff followed the MD order for 10 days of precautions, which was ordered on June 14, 2024; however, he confirmed that precautions should have been continued while Resident 52 was actively being treated or, at the very least, staff should have followed up with the MD for further guidance. During a follow-up interview with the Nursing Home Administrator (NHA) and DON on July 3, 2024, at 10:55 AM, the DON indicated that Resident 52 was restarted on contact precautions on July 2, 2024, and that a new area of shingles had been identified. He again confirmed that Resident 52's contact precautions should have continued or that their physician should have been notified for guidance on precautions since they were actively being treated for ongoing shingles. Review of Resident 326's clinical record revealed diagnoses that included bacteremia (bacteria in the blood) and excoriation disorder (a mental illness related to obsessive-compulsive disorder characterized by repeated picking at the skin). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 326's physician orders revealed an order dated June 30, 2024, that read this Resident is on EBP (enhanced barrier precautions), use gown and gloves for high-contact care activities, such as dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, every shift. Review of Resident 326's care plan revealed a focus area for enhanced barrier precautions: mid line IV (intravenous line) with an intervention for EBP sign on door/isolation bin outside of room. Observations of Resident 326's room on July 1, 2024, at 10:44 AM, and July 2, 2024, at 8:24 AM, failed to reveal signage for EBP or a PPE caddy. During a staff interview on July 3, 2024 at 10:55 AM, with the NHA and DON, it was revealed that Resident 326 should have been placed on EBP at the time of the physician's order and it is the expectation of the facility that EBP be followed. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services