

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395740	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/03/2024
NAME OF PROVIDER OR SUPPLIER  West Chester Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 West Miner Street West Chester, PA 19382	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>41765</p> <p>Based on clinical records review and staff interviews, it was determined that the facility failed to notify the physician of a significant weight change for one of the 33 residents reviewed (Resident 21).</p> <p>Findings include:</p> <p>Review of Resident 21's diagnosis list includes End Stage Renal Disease (ESRD- kidney function has declined to the point that the kidneys can no longer function on their own), Heart Failure (condition in which the heart does not pump blood as well as it should), and Diabetes (group of metabolic disorders characterized by a high blood sugar level over a prolonged period).</p> <p>Review of Resident 21's clinical records revealed resident is on Hemodialysis (process of purifying the blood of a person whose kidneys are not working normally) three times a week.</p> <p>Review of Resident 21's weights and vitals documentation dated August 14, 2024, revealed a weight of 309 pounds and a weight of 322.7 pounds on August 21, 2024, which is a 13.7 pound weight gain in a week.</p> <p>Review of Resident 21's clinical records failed to reveal the physician was notified of the above weight changes.</p> <p>Review of Resident 21's weights and vitals documentation dated August 28, 2024, revealed a weight of 321.3 pounds and a weight of 330.6 pounds on September 11, 2024. Clinical records review revealed that Resident 21 had a total of 21.6 pounds (6.99%) weight gain, a significant weight change in less than a month.</p> <p>Review of Resident 21's clinical records failed to reveal the physician was notified of Resident 21's significant weight change.</p> <p>Interview with Licensed Employee E9 on October 3, 2024, at 10:45 a.m., confirmed that Resident 21's significant weight change was identified but the physician was not notified of these changes.</p> <p>The facility failed to ensure physician was notified of Resident 21's significant weight change.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>47968</p> <p>Based on clinical records review, and resident, and staff interviews, it was determined that the facility failed to include the Interdisciplinary Team (IDT) in care plan meetings for 15 out of 15 resident care plan meetings reviewed (Residents 23, 27, 38, 66, 78, 85, 98, 101, 107, 114, 119, 121, 134, 143, 161).</p> <p>Findings include:</p> <p>Review of federal regulations revealed resident care plans should be prepared by an interdisciplinary team that includes but is not limited:</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>Review of Resident 23's Care Plan Meeting Review dated September 13, 2024, revealed Interdisciplinary Team attendance of social services and therapy. The resident's health precluded attendance.</p> <p>Review of Resident 27's Care Plan Meeting Review dated September 10, 2024, revealed Interdisciplinary Team attendance of social services and nursing. The resident attended in person.</p> <p>Review of Resident 38's Care Plan Meeting Review dated September 13, 2024, revealed Interdisciplinary Team attendance of social services and therapy. The resident's health precluded attendance.</p> <p>Review of Resident 66's Care Plan Meeting Review dated September 20, 2024, revealed Interdisciplinary Team attendance of social services, nursing and respiratory. The resident attended in person.</p> <p>Review of Resident 78's Care Plan Meeting Review dated September 4, 2024, revealed Interdisciplinary Team attendance of social services, nursing and dietary. The resident's health precluded attendance.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 85's Care Plan Meeting Review dated September 10, 2024, revealed Interdisciplinary Team attendance of social services and nursing. The resident's health precluded attendance.</p> <p>Review of Resident 98's Care Plan Meeting Review dated September 3, 2024, revealed Interdisciplinary Team attendance of social services and nursing. The resident attended in person.</p> <p>Review of Resident 101's Care Plan Meeting Review dated September 5, 2024, revealed Interdisciplinary Team attendance of social services and nursing. The resident's health precluded attendance.</p> <p>Review of Resident 107's Care Plan Meeting Review dated September 9, 2024, revealed Interdisciplinary Team attendance of social services, therapy and respiratory. The resident's health precluded attendance.</p> <p>Review of Resident 114's Care Plan Meeting Review dated September 5, 2024, revealed Interdisciplinary Team attendance of social services, dietary and nursing. The resident attended in person.</p> <p>Review of Resident 119's Care Plan Meeting Review dated September 6, 2024, revealed Interdisciplinary Team attendance of social services, dietary and nursing. The resident attended in person.</p> <p>Review of Resident 121's Care Plan Meeting Review dated September 5, 2024, revealed Interdisciplinary Team attendance of social services and nursing. The resident attended in person.</p> <p>Review of Resident 134's Care Plan Meeting Review dated September 13, 2024, revealed Interdisciplinary Team attendance of social services and therapy. The resident attended in person.</p> <p>Review of Resident 143's Care Plan Meeting Review dated September 10, 2024, revealed Interdisciplinary Team attendance of social services, therapy, and nursing. The resident attended in person.</p> <p>Review of Resident 161's Care Plan Meeting Review dated September 5, 2024, revealed Interdisciplinary Team attendance of social services and therapy. The resident's health precluded attendance.</p> <p>The above information was conveyed and confirmed with the Regional Director, the Nursing Home Administrator, and the Director of Nursing on October 1, 2024, at 12:20 p.m.</p> <p>28 Pa Code 211.11(d) Resident care plan</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 record review, resident and staff interviews, it was determined the facility failed to follow the physician's order for two of the 33 residents reviewed (Resident 13 and Resident 419).</p> <p>Findings include:</p> <p>Review of Resident 13's diagnosis list includes Chronic kidney Disease (kidneys are damaged and cannot filter blood the way they should), and Hyponatremia (condition that occurs when the level of sodium in the blood is too low).</p> <p>Review of Resident 13's physician's order dated August 22, 2024, revealed an order for Fluid restriction of 1500ml per day. 840 cc allocated to dietary, 660 cc allocated to nursing. Nursing 6:00 a.m.-2:00 p.m. = 270 cc; 2:00 p.m.-10:00 p.m. =270 cc. Dietary: breakfast - 360 cc; lunch - 240 cc; and dinner - 240 cc.</p> <p>Review of Resident 13's August 2024 and September 2024, Medication Administration Records revealed the above orders were written with a box for the morning and evening shifts indicated with a check mark.</p> <p>Review of Resident 13's clinical records failed to reveal Resident 13's fluid intake was monitored to ensure fluid restriction of 1500 cc per day was followed.</p> <p>Observation conducted on October 1, 2024, at 1:20 p.m., revealed Resident 13 was eating lunch. The lunch tray included one cup of coffee and a four-ounce juice box. A 16-ounce Styrofoam cup filled with water was also observed on the resident's side table.</p> <p>Observation of Resident 13 on October 2, 2024, at 12:30 p.m., revealed two 16-ounce Styrofoam cups on the resident's bedside table. One cup was empty, and the other was 1/4 filled with water.</p> <p>Interview with Resident 13 on October 2, 2024, at 12:31 p.m., revealed that she/he drank all the water in one cup but did not want to finish the water on the other cup since it was already warm. The resident asked if she/he could have more water.</p> <p>Interview with Licensed nurse Employee E8 was conducted on October 2, 2024, at 12:23 p.m. Employee E8 indicated she/he was Resident 13's nurse for the day. When asked how much fluid Resident 13 can have, Employee E8 responded I'm not sure. When asked if the resident was on any fluid restriction, Employee E8 responded I don't recall.</p> <p>The above information was conveyed to the Director of Nursing on October 3, 2024, at 11:00 a.m.</p> <p>The facility failed to ensure Resident 13's physician's order for a fluid restriction was followed.</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 - Few</p>	<p>Review of Resident 419's diagnosis list includes acute and Chronic Respiratory Failure with Hypercapnia (the lungs are unable to adequately excrete carbon dioxide), Chronic Obstructive Pulmonary Disease (damage to the lungs), Diabetes Mellitus Type II (in ability to regulate one's blood sugar), Parkinsonism (condition that affects movement), and Chronic Kidney Disease Stage 4 (loss of kidney function).</p> <p>Review of Resident 419's physician orders dated June 27, 2024, revealed an order for Morphine Sulfate Oral Solution 20MG/ML, give 0.25 ml (milliliter) by mouth every 3 hours as needed for moderate to severe pain and dyspnea (shortness of breath).</p> <p>Review of Resident 419's physician orders dated July 3, 2024, revealed an order for Morphine Sulfate Oral Solution 20 MG/ML give 5mg by mouth every 3 hours for pain/anxiety.</p> <p>Further review of Resident 419's physician order revealed an order dated July 3, 2024, for Morphine Sulfate Oral Solution 20 MG/ML give 5mg by mouth every (one) hour as needed for air hunger.</p> <p>Review of facility documents revealed the orders were entered by Registered Nurse, Employee E12 as Morphine Sulfate Oral Solution 20MG/5ML, give 5ml by mouth every 3 hours for pain/anxiety.</p> <p>Further review of facility documents revealed an additional order was entered by Registered Nurse, Employee E12 as Morphine Sulfate Oral Solution 20MG/5ML, give 20 ml by mouth every (one) hour as needed for air hunger.</p> <p>Review of Resident 419's July 2024, Medication Administration Record (MAR) revealed on July 3, 2024, the resident received 5 ml of Morphine Sulfate Oral Solution at 9:00 a.m., 12:00 p.m., 3:00 p.m., and 6:00 p.m.</p> <p>Further review of Resident 419's July 2024 MAR revealed on July 3, 2024, the resident received one PRN dosage of 20 ml of Morphine for air hunger.</p> <p>Review of the facility's narcotic logbook revealed Resident 419 received the following amounts on July 3, 2024:</p> <p>12:00 a.m. - 0.25 ml (5mg)</p> <p>3:55 a.m. - 0.25 ml (5mg)</p> <p>6:00 a.m. - 0.25 ml (5mg)</p> <p>10:00 a.m. - 0.25 ml (5mg)</p> <p>12:00 p.m. - 0.5 ml (10mg)</p> <p>1:30 p.m. - 0.5 ml (10mg)</p> <p>3:00 p.m. - 0.25 ml (5mg)</p> <p>6:00 p.m. - 0.25 ml (5mg)</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 - Few</p>	<p>Review of facility investigative documents including Medication Incident Details dated July 5, 2024 revealed the resident was administered an incorrect dose of Morphine.</p> <p>Further review of the Medication Incident Detail document revealed Resident 419 was administered 20 mg/5 ml give 5 ml. The medication ordered was 20 mg/5 ml give 5 mg.</p> <p>Additional review of Medication Incident Detail document revealed no adverse effect (of Resident 419). Med (medication) was given per recommendation, not per order. The document further indicates the medication error was a transcription error.</p> <p>The above information was conveyed and confirmed with the Nursing Home Administrator and the Director of Nursing on October 3, 2024, at 1:45 p.m.</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</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>41765</p> <p>Based on clinical record review and staff interview, it was determined the facility failed to ensure resident was free from unnecessary medication for one of 33 residents reviewed (Resident 21).</p> <p>Findings include:</p> <p>Review of Resident 21's diagnosis list includes Spinal Stenosis (narrowing of one or more spaces within the spinal canal), and chronic back pain.</p> <p>Review of Resident 21's physician order dated September 9, 2024, revealed an order for Oxycodone HCL (A medication used to treat severe pain) 10 mg Give one tablet by mouth every six hours as needed for moderate pain.</p> <p>Review of Resident 21's September 2024, Medication Administration Record (MAR) revealed that from September 9, 2024, until September 30, 2024, the Oxycodone medication was administered to Resident 21 a total of 11 times with a pain level rating of 0 (Numeric Pain Scale: 0-no pain; 1-3-mild pain; 4-6-moderate pain; 7-10-severe pain).</p> <p>Review of Resident 21's clinical record failed to reveal an explanation as to why the resident was administered with as needed Oxycodone for a pain level rating of 0.</p> <p>The above was conveyed to the Director of Nursing on October 3, 2024, at 11:00 a.m.</p> <p>The facility failed to ensure Resident 21 was free from unnecessary use of as-needed Oxycodone.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>41765</p> <p>Based on review of the medication manufacturer's guidelines, the facility's policy, observation, and staff interviews, it was determined the facility failed to ensure medications were properly labeled and stored on two of two medication carts observed (Medication Carts 4 and 5).</p> <p>Findings include:</p> <p>Review of the facility policy titled Medication Labeling and Storage, revised February 2023, revealed medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. The same policy indicated that multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.</p> <p>Review of the manufacturer's storage guidelines for Insulin Lispro (Humalog-fast-acting insulin), revealed the medication must be stored at room temperature and must be discarded within 28 days after opening.</p> <p>Review of the manufacturer's guidelines for Basaglar Insulin Kwikpen (long-acting insulin) revealed the medication should be discarded 28 days after opening or removal from refrigeration.</p> <p>Observation of the medication cart 4 was conducted in the presence of Licensed nurse Employee E10 on October 1, 2024, at 9:07 a.m. The observation revealed one Lispro pen and one Basaglar pen. Both insulin pens were used and undated. Additional observation revealed 97 loose medications in different sizes and colors scattered on the medication cart drawers.</p> <p>Observation of the medication cart 5 was conducted in the presence of Licensed nurse Employee E11 on October 1, 2024, at 9:31 a.m. The observation revealed one Lispro pen, one Admelog pen, and one Lantus pen each placed in a clear zip-lock bag with the resident's name written in pentel pen. Additional observation revealed 50 loose medications in different sizes and colors scattered on the medication cart drawers. A Lidocaine (medication used to numb the skin) vial, used, undated with no name was observed.</p> <p>Interview conducted with Employee E11 on October 1, 2024, at 9:40 a.m. revealed the pharmacy sent multiple insulins for the residents, the original container was left in the medication refrigerator and the insulin currently in use was placed on a zip lock bag with the resident 's name written in pentel pen. Employee E11 reported that the scattered medications in the drawers were when the medication was accidentally popped out from the blister medication packages.</p> <p>The above findings were conveyed to the Director of Nursing on October 3, 2024, at 1:00 p.m.</p> <p>The facility failed to ensure medications were properly labeled and stored on medication carts 4 and 5.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>35913</p> <p>Based on review of staff documentation, it was determined the facility failed to ensure the required 12 hours of annual training was completed by four of five staff members reviewed (Employee E3, Employee E4, Employee E5 and Employee E6).</p> <p>Findings include:</p> <p>Review of Employees E3, E4, E5 and E6's training documentation regarding 12-hour annual training failed to reveal evidence that Employees E3, E4, E5, and E6 completed the annual 12-hour training as required.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on October 3, 2024, at 2:30 p.m. confirmed Employees E3, E4, E5 and E6 did not complete the required 12-hour annual training.</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management</p> <p>Previously cited 5/6/2024</p>