

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/11/2024
NAME OF PROVIDER OR SUPPLIER  Carlisle Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  940 Walnut Bottom Road Carlisle, PA 17013	

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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>37116</p> <p>Based on clinical record review, hospital records, staff interviews, and review of the facility incident report, it was determined that the facility failed to ensure that care and services were provided timely following a fall with fracture for one of three residents reviewed (Resident 1), which resulted in harm as evidenced by uncontrolled fracture-related pain and delayed corrective treatment.</p> <p>Findings include:</p> <p>Review of Resident 1's clinical record revealed diagnoses that included atrial fibrillation (irregular heart beat), congestive heart failure (CHF - weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues), and chronic obstructive pulmonary disease (COPD - chronic inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>Review of the facility incident report, revealed that Resident 1 experienced an unwitnessed fall between 4:45 and 5:00 AM on April 3, 2024. Further review of the report revealed, resident was found lying on the bathroom floor after staff had noted knocking noise coming from resident's bathroom. Resident states that she thought she had her call light on (light was not on) and wanted to go to the bathroom. Resident had ambulated without staff assistance and had fallen onto back. Noted resident stating discomfort in left wrist. On assessment, swelling/bruising noted. Resident transferred to bed. Left arm elevated and cool compress applied. MD [doctor] updated, xray of left wrist to be obtained. The pain level evaluation documented on the incident report indicated a pain level of 3 out of 10 with facial grimacing noted.</p> <p>Review of Resident 1's clinical record failed to reveal any evidence that neurovascular assessments (evaluation for impaired blood flow to the extremities) were completed following Resident 1's wrist injury.</p> <p>Review of nursing progress note dated April 3, 2024, revealed that at 6:04 AM the X-ray was ordered.</p> <p>Review of Resident 1's April 2024 MAR (Medication Administration Record - form used to document physician orders as well as when and how medications are administered to a resident) revealed an order for Norco (opioid pain medication used to treat moderate to severe pain) every 12 hours as needed for pain, effective April 2, 2024. Further review revealed it was administered to Resident 1 at 8:27 AM on April 3, 2024. Review of the MAR revealed that Employee 2 (Licensed Practical Nurse) documented that the Norco was ineffective in treating Resident 1's pain.</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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The x-ray was completed at 9:29 AM; three hours and 25 minutes after it was ordered.</p> <p>Review of Resident 1's X-ray report revealed that Resident 1 had a fracture involving the distal radius with mild displacement (wrist fracture).</p> <p>At 10:15 AM, MD 1 was notified via text message of the X-ray results and that Resident 1 was requesting to go to the emergency room .</p> <p>Review of Resident 1's April 2024 MAR, revealed that at 10:20 AM on April 3, 2024, the Resident's pain level had increased, and was noted to be a 5 out of 10, and Tylenol 650 mg was administered to her at that time. Further review revealed that it was notated by Employee 2 that the Tylenol was ineffective in treating Resident 1's pain.</p> <p>On April 3, 2024, at 12:12 PM, Resident 1 refused wound care stating, I have so much pain in my arm. I can't do it right now.</p> <p>Approximately two hours after being notified of Resident 1's x-ray results, MD 1 responded to the notification and gave orders to transfer Resident 1 to the hospital. Review of physician order details revealed that the order to send Resident 1 to the emergency room was created and confirmed by Employee 5 at 12:19 PM on April 3, 2024.</p> <p>Review of Resident 1's hospital records dated April 3, 2024, revealed that upon arrival to the hospital: Resident 1 reported a pain rating of 6 out of 10 and received Fentanyl (opioid medication used to treat severe pain) in the emergency department; Resident 1 was noted to have obvious deformity and immediate pain following her fall; Resident 1 was diagnosed with acute impacted comminuted displaced angulated intra-articular fracture of the distal radius [type of fracture involving the distal radius (the forearm bone near the wrist) being broken in multiple places, with the bone fragments shifted and potentially affecting the joint], with substantial surrounding posttraumatic soft tissue swelling.</p> <p>Further review of the hospital records revealed Resident 1 required local anesthesia and a closed reduction (a non-invasive procedure where the broken bone is put back into place, allowing for it to grow back together in better alignment; best prognosis when performed as soon as possible after the bone breaks).</p> <p>During an interview with Employee 2 on April 8, 2024, at 9:44 AM, he confirmed that Resident 1 was alert and oriented. He revealed that on the day of Resident 1's fall, Resident 1 informed him that her wrist was very painful. Employee 2 confirmed that he administered pain medication to Resident 1, after which Resident 1 stated the pain subsided a little bit but was still present. Employee 2 revealed that Resident 1's wrist appeared abnormal. Employee 2 also revealed that Resident 1 refused wound treatment due to wrist pain, and asked to be sent to the hospital.</p> <p>During an interview with Employee 4 (Registered Nurse) on April 8, 2024, at 10:06 AM, she revealed that she assessed Resident 1 following her fall. She revealed that Resident 1 had bruising and swelling to her left wrist, and that Resident 1 stated there was some discomfort.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Employee 6 on April 8, 2024, at 10:41 AM, Employee 6 revealed that on the date of Resident 1's fall, when she delivered Resident 1's breakfast tray, Resident 1 was hysterically crying and was in pain. Employee 6 stated that Resident 1's wrist appeared abnormal. Employee 6 stated that she tried to reassure Resident 1, who ate a little bit of her breakfast and dozed off. When Resident 1 awoke, she put her call light on again. Per Employee 6, Resident 1 stated she couldn't take the pain anymore and asked if she could have anything for pain. Employee 6 stated that she spoke to Employee 2 about this request, who informed her that he had already given Resident 1 pain medication and could not readminister it for another 12 hours, but that he would give Resident 1 Tylenol. Employee 6 stated that Resident 1 requested to be taken to the hospital, which Employee 6 stated she passed along to Employee 3 (Licensed Practical Nurse). Employee 6 also stated she informed Employee 5 (Registered Nurse) that Resident 1 was in a lot of pain.</p> <p>During an interview with Employee 5 April 8, 2024, at 10:52 AM, she revealed that when she received Resident 1's x-ray results, she went back to talk to Resident 1. She revealed that Resident 1's wrist was swollen, probably more than I thought it was going to be based on report. She revealed that she spoke to Resident 1's son and informed him that she had notified MD 1 about the x-ray and was awaiting a response. Employee 5 confirmed that there was a time lapse of a couple of hours between the time she notified MD 1 of the x-ray results, and when the facility received the physician response/order to transfer Resident 1 to the emergency room .</p> <p>Per email correspondence received from the Nursing Home Administrator on April 11, 2024, at 12:50 PM, she confirmed that as soon as Employee 5 received Resident 1's x-ray results, she notified MD 1 of the results via text message at 10:15 AM on April 3, 2024.</p> <p>During an interview with the Director of Nursing on April 8, 2024, at 12:31 PM, she revealed the expectation that if Resident 1 was experiencing uncontrolled pain, an assessment should have been completed and the physician should have been notified. She confirmed that she was not able to locate evidence that neurovascular assessments were completed following Resident 1's injury, but that she would expect that a Registered Nurse would complete these assessments and document them in the clinical record. Lastly, she revealed the expectation that the physician would have responded to the facility request to transfer Resident 1 in a timely manner, and that when a timely response was not received, nursing staff should have reached out to the physician again, and if still no response, staff should have contacted another facility physician, possibly the Medical Director.</p> <p>Review of Resident 1's clinical record failed to reveal any evidence that the physician was notified of Resident 1's unmanaged pain, or that the facility took any additional steps to manage her uncontrolled pain at any point during the timeframe between her fall and her transfer to the hospital (approximately 7 hours and 45 minutes). Additionally, the facility failed to complete neurovascular assessments to ensure proper circulation following injury, and failed to act timely to ensure Resident 1's transfer to the hospital following her fall.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		