

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 07/18/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>46253</p> <p>Based on facility policy review, clinical record review, observations, and staff interviews, it was determined that the facility failed to promote care for residents in a manner and environment that enhances each resident's dignity for four of four Residents reviewed (Residents 5, 25, 40, and 54).</p> <p>Findings include:</p> <p>Review of facility policy, titled OPS200 Accommodation of Needs, with a last review date of April 24, 2024, revealed, in part, that the Center's physical environment and staff behaviors should be directed toward assisting the patient in maintaining and/or achieving independent functioning, dignity, and wellbeing to the extent possible in accordance with the patient's own needs and preferences.</p> <p>Review of facility policy, titled OPS206 Resident Rights Under Federal Law, with a last review date of April 24, 2024, indicated under the section titled Purpose, that the facility was to 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/her self-esteem and self-worth. Also, in Section 1 Resident Rights revealed at 1.1 The facility to 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/her quality of life, recognizing each resident's individuality.</p> <p>Review of Resident 5's clinical record revealed diagnoses that included vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults), cognitive communication deficit (difficulty in thinking and how someone uses language), and aphasia (loss of ability to understand or express speech).</p> <p>Observations of Resident 5 on July 15, 2024, at 10:18 AM; July 16, 2024, at 8:27 AM; and July 17, 2024, at 8:59 AM, revealed that a stack of approximately eight to 10 of their incontinent briefs were lying out on their nightstand in public view.</p> <p>Review of Resident 25's clinical record revealed diagnoses that included dementia (brain damage caused by multiple strokes which causes memory loss in older adults) and cerebral infarction (a stroke - damage to the brain from interruption of its blood supply).</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations of Resident 25 on July 15, 2024, at 9:35 AM; July 16, 2024, at 10:49 AM; and July 17, 2024, at 8:57 AM, revealed that a stack of approximately eight to 10 of their incontinent briefs were lying out on their nightstand in public view.</p> <p>Review of Resident 40's clinical record revealed diagnoses that included paranoid schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, behavior, and intense, irrational, persistent instinct or thought process of fearful feelings and thoughts) and muscle weakness.</p> <p>Observations of Resident 40 on July 15, 2024, at 12:35 PM; July 16, 2024, at 10:26 AM; and July 17, 2024, at 8:59 AM, revealed that a stack of approximately eight to 10 of their incontinent briefs were lying out on their nightstand in public view.</p> <p>Review of Resident 54's clinical record revealed diagnoses that included vascular dementia and mild intellectual disabilities.</p> <p>Observations of Resident 54 on July 15, 2024, at 11:35 AM; July 16, 2024, at 10:10 AM; and July 17, 2024, at 9:42 AM, revealed that a stack of approximately eight to 10 of their incontinent briefs were lying out on their nightstand in public view.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on July 17, 2024, at 1:09 PM, all the observations were shared. The DON indicated that she understood the concern and would review the facility policy.</p> <p>In an email communication received from the DON on July 17, 2024, at 5:00 PM, the DON indicated that the facility did not have a policy on how incontinent briefs should be stored.</p> <p>During an interview with Employee 4 (Nurse Aide) on July 18, 2024, at 9:54 AM, Employee 4 indicated that they had always stored briefs on nightstands in resident rooms as this was the facility practice for all residents. Employee 4 further indicated that they had been off work yesterday and, when they returned today, they were told that incontinent briefs were now to be stored inside a drawer.</p> <p>During a final interview with the NHA and DON on July 18, 2024, at 10:38 AM, the DON indicated that they were looking at the facility process for the storing of incontinent briefs because some residents may prefer to have them on their nightstands. The DON confirmed that Residents 5, 25, 40, and 54 were not capable of stating whether they would want their incontinent briefs stored out in open view.</p> <p>28 Pa. Code 201.18(b)(2) Management</p> <p>28 Pa. Code 201.29(a) Resident rights</p> <p>28 Pa. Code 211.12(d)(1)(2) Nursing services</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>46253</p> <p>Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to maintain a safe, clean, and home-like environment on one of three units observed (East Lounge).</p> <p>Findings include:</p> <p>Review of facility policy, titled OPS200 Accommodation of Needs, with a review date of April 24, 2024, revealed, in part, that the Center's physical environment and staff behaviors should be directed toward assisting the patient in maintaining and/or achieving independent functioning, dignity, and wellbeing to the extent possible in accordance with the patient's own needs and preferences.</p> <p>Observation of East Lounge on July 15, 2024, at 10:52 AM, revealed that approximately 20 empty wheelchairs/specialty chairs used for resident mobility were stored.</p> <p>During this observation, Resident 26 was observed to ambulate into the lounge using their walker. Resident 26 stepped away from their walker to move an empty wheelchair that was pushed up against a table displaying a jigsaw puzzle. After moving the wheelchair, Resident 26 retrieved their walker and proceeded to sit in an empty chair at the table and began working on the displayed puzzle.</p> <p>Observation of the East Lounge on July 16, 2024, at 11:00 AM, revealed that there were 16 wheelchairs/specialty chairs present at the back of the room away from tables.</p> <p>Observation of the East Lounge on July 17, 2024, at 8:55 AM, revealed that there were 21 wheelchairs/specialty chairs and one walker present at the back of the room away from tables.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on July 17, 2024, at 1:10 PM, the observations were shared to include the observation of Resident 26. The DON indicated that the facility does store the chairs there but confirmed that an empty wheelchair should not be stored up against the table blocking a resident's access to the puzzle table.</p> <p>Email communication received from the NHA on July 17, 2024, at 8:11 PM, revealed that as a response to surveyor observations, the team was able to creatively remove several chairs and that there were now only eight resident specialty chairs in the lounge that were currently being utilized by residents that did not have space in their rooms to store them.</p> <p>During an interview with the NHA and DON on July 18, 2024, at 10:37 AM, the NHA and DON both confirmed that the chairs should have been stored in a manner that they would not have impeded a resident's access to an activity (puzzle) in the lounge.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</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>28 Pa. Code 211.10(d) Resident care policies</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>46253</p> <p>Based on review of clinical records, facility policy review, and staff interview, it was determined that the facility failed to ensure that all alleged violations involving abuse, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for one of two residents reviewed (Resident 57).</p> <p>Findings include:</p> <p>Review of facility policy, titled OPS300 Abuse Prohibition, with a last revision date of October 24, 2022, and last review date of April 24, 2024, revealed, in part, under section titled External Abuse Reporting Requirements that reporting requirements as based on real (clock) time, not business hours and that for incidents with no serious bodily injury that reporting to law enforcement and adult protective services where state laws provide jurisdiction in long-term care facilities should be reported immediately but no later than 24 hours after forming the suspicion.</p> <p>Review of Resident 57's clinical record revealed diagnoses that included liver failure and muscle weakness.</p> <p>Review of facility documentation revealed that Resident 57 reported an allegation of physical abuse by a staff member on January 22, 2024, at 3:15 PM, and that the facility initiated an immediate investigation. Further review of the facility documentation revealed that the facility concluded the investigation on January 23, 2024, at 3:00 PM.</p> <p>Review of the facility investigation revealed Resident 57's allegation of physical abuse was reported to the Pennsylvania Department of Aging on January 23, 2024, at 5:11 PM; to the local police on January 24, 2024, at 10:20 AM; and to the local Area Agency on Aging on January 24, 2024, at 3:30 PM, indicating that all required reporting was completed past the 24-hour requirements.</p> <p>During an interview with the Nursing Home Administrator and Director of Nursing on July 17, 2024, at 1:44 PM, the NHA confirmed that there was a delay in completing the required reporting.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(2)(3) Management</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to provide a notice of transfer to residents and/or resident representatives, or to the Office of the State Long-Term Care Ombudsman for eight of 11 residents reviewed for hospital transfers (Residents 5, 7, 22, 25, 27, 39, 54, and 103).</p> <p>Findings include:</p> <p>Review of Resident 5's clinical record revealed diagnoses that included vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults), cognitive communication deficit (difficulty in thinking and how someone uses language), and aphasia (loss of ability to understand or express speech).</p> <p>Review of Resident 5's clinical record revealed that the Resident was transferred to the hospital on April 19, 2024, and returned to the facility on [DATE].</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on July 18, 2024, at 10:40 AM, the NHA confirmed that the facility was unable to provide documentation that Resident 5's responsible party or the Pennsylvania State Ombudsman was notified of their transfer to the hospital.</p> <p>Review of Resident 7's clinical record revealed diagnoses that included congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to meet your body's needs), chronic kidney disease (a condition characterized by a gradual loss of kidney function), and hypertension (high blood pressure).</p> <p>Review of Resident 7's clinical record revealed that the Resident was transferred to the hospital on May 12, 2024, and returned to the facility on [DATE].</p> <p>During an interview with the NHA on July 17, 2024, at 1:06 PM, the NHA confirmed that the facility was unable to provide documentation that the Pennsylvania State Ombudsman was notified of the Resident's transfer to the hospital; she further revealed they are working to change their current process.</p> <p>Review of Resident 22's clinical record revealed diagnoses the included dementia (progressive, irreversible degenerative disease of the brain that results in decreased contact with reality and decreased ability to perform activities of daily living) and type two diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment).</p> <p>Review of Resident 22's clinical record revealed that on January 17, 2024, Resident 22 was transferred to the hospital and returned on January 19, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of available documentation provided by the facility and contained in Resident 22's clinical record revealed no evidence that Resident 22 was provided with a notice of transfer from the facility.</p> <p>During a staff interview on July 18, 2024, at approximately 10:50 AM, the NHA confirmed the facility did not have evidence that Resident 22 was provided with a transfer notice. During the interview, the NHA revealed that hospital provision of transfer notices was a process that the facility was working towards improving.</p> <p>Review of Resident 25's clinical record revealed diagnoses that included dementia (brain damage caused by multiple strokes which causes memory loss in older adults) and cerebral infarction (a stroke - damage to the brain from interruption of its blood supply).</p> <p>Review of Resident 25's clinical record revealed that the Resident was transferred to the hospital on May 15, 2024, and returned to the facility on [DATE].</p> <p>During an interview with the NHA and DON on July 18, 2024, at 10:40 AM, the NHA confirmed that the facility was unable to provide documentation that Resident 25's responsible party or the Pennsylvania State Ombudsman was notified of their transfer to the hospital.</p> <p>Review of Resident 27's clinical record revealed diagnoses that included End Stage Renal Disease (condition where one's kidneys are functioning below 10 percent of their normal function) and diabetes mellitus (condition results from insufficient production of insulin, causing high blood sugar).</p> <p>Further review of Resident 27's clinical record revealed that she was transferred to the hospital on March 9, 2024, following a change in condition and was subsequently admitted .</p> <p>Review of available documentation revealed no evidence that Resident 27 or her representative were provided with a notice of transfer related to her March 9, 2024, hospitalization , or that the Office of the State Long-Term Care Ombudsman was notified of the transfer.</p> <p>Review of Resident 39's clinical record revealed diagnoses that included cerebral infarction and End Stage Renal Disease.</p> <p>Further review of Resident 39's clinical record revealed that she was transferred to the hospital on April 8, 2024, and on July 4, 2024, for evaluation following a fall on each of those dates and was subsequently admitted .</p> <p>Review of available documentation revealed no evidence that Resident 39 or her representative were provided with a notice of transfer related to her April 2024 and July 2024 hospitalization s, or that the Office of the State Long-Term Care Ombudsman was notified of the transfers.</p> <p>During an interview with the NHA on July 18, 2024, at 10:32 AM, she revealed that she was not able to provide evidence that Resident 27, Resident 39, their representatives, or the Office of the State Long-Term Care Ombudsman were provided with a notice of transfer related to their aforementioned hospitalization s.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879</p> <p>Based on policy review, clinical record review, and staff interviews, it was determined that the facility failed to provide residents and/or resident representatives with the facility's bed hold policy upon transfer for seven of 11 residents reviewed for hospitalization (Residents 5, 7, 25, 27, 39, 54, and 103).</p> <p>Findings include:</p> <p>Review of facility policy, Bed Hold Notice - Deliver Upon Transfer, revised August 5, 2022, revealed that staff are to complete the Bed Hold Notice Form, deliver it to the resident or representative (if there is one), and note delivery of the notice in the electronic health record.</p> <p>Review of Resident 5's clinical record revealed diagnoses that included vascular dementia (brain damage caused by multiple strokes, which causes memory loss in older adults), cognitive communication deficit (difficulty in thinking and how someone uses language), and aphasia (loss of ability to understand or express speech).</p> <p>Review of Resident 5's clinical record revealed that the Resident was transferred to the hospital on April 19, 2024, and returned to the facility on [DATE].</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on July 18, 2024, at 10:40 AM, the NHA confirmed that the facility was unable to provide documentation that Resident 5's responsible party received the facility bed hold policy at the time of Resident 5's hospitalization .</p> <p>Review of Resident 7's clinical record revealed diagnoses that included congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to meet your body's needs), chronic kidney disease (a condition characterized by a gradual loss of kidney function) and hypertension (high blood pressure).</p> <p>Review of Resident 7's clinical record revealed that the Resident was transferred to the hospital on May 12, 2024, and returned to the facility on [DATE].</p> <p>During an interview with the NHA July 18, 2024, at 10:28 AM, she confirmed that the facility was unable to provide documentation that Resident 7 or his responsible party received the facility bed hold notice at the time of his hospitalization .</p> <p>Review of Resident 25's clinical record revealed diagnoses that included dementia (brain damage caused by multiple strokes which causes memory loss in older adults) and cerebral infarction (a stroke - damage to the brain from interruption of its blood supply).</p> <p>Review of Resident 25's clinical record revealed that the Resident was transferred to the hospital on May 15, 2024, and returned to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the NHA and DON on July 18, 2024, at 10:40 AM, the NHA confirmed that the facility was unable to provide documentation that Resident 5's and Resident 25's responsible party received the facility bed hold policy at the time of their aforementioned hospitalization s.</p> <p>Review of Resident 27's clinical record revealed diagnoses that included End Stage Renal Disease (condition where one's kidneys are functioning below 10 percent of their normal function) and diabetes mellitus (condition results from insufficient production of insulin, causing high blood sugar).</p> <p>Further review of Resident 27's clinical record revealed that she was transferred to the hospital on March 9, 2024, following a change in condition, and was subsequently admitted .</p> <p>Review of available documentation provided by the facility revealed no evidence that Resident 27 or her representative were provided with the facility's bed hold policy upon transfer.</p> <p>Review of Resident 39's clinical record revealed diagnoses that included cerebral infarction and End Stage Renal Disease.</p> <p>Further review of Resident 39's clinical record revealed that she was transferred to the hospital on April 8, 2024, and on July 4, 2024, for evaluation following a fall on each of those dates and was subsequently admitted .</p> <p>Review of available documentation provided by the facility revealed no evidence that Resident 39 or her representative were provided with the facility's bed hold policy upon transfer.</p> <p>During an interview with the NHA on July 18, 2024, at 10:32 AM, she revealed that she was not able to locate any evidence that a notice of the bed hold policy was provided to either Resident 27, Resident 39, or their representatives when they were transferred and admitted to the hospital on the aforementioned dates.</p> <p>Review of Resident 54's clinical record revealed diagnoses that included vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults) and mild intellectual disabilities.</p> <p>Review of Resident 54's clinical record revealed that the Resident was transferred to the hospital on May 21, 2024, and returned to the facility on [DATE].</p> <p>During an interview with the NHA and DON on July 18, 2024, at 10:40 AM, the NHA confirmed that the facility was unable to provide documentation that Resident 54's responsible party received the facility bed hold policy at the time of Resident 54's hospitalization .</p> <p>Review of Resident 103's clinical record revealed diagnoses that included dementia (progressive, irreversible degenerative disease of the brain that results in decreased contact with reality and decreased ability to perform activities of daily living) and hypertension (elevated/high blood pressure).</p> <p>Review of Resident 103's clinical record revealed that on May 5, 2024, Resident 103 was transferred to the hospital due to an emergency health need. Resident 103 returned to the facility the following day on May 6, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of available documentation provided by the facility revealed no evidence that Resident 103 was provided with the facility's bed hold policy upon transfer.</p> <p>During a staff interview on July 18, 2024, at approximately 10:50 AM, NHA confirmed the facility did not have evidence that Resident 103 was provided with a bed hold notice. During the interview, the NHA revealed that hospital provision of bed hold notices was a process that the facility was working towards improving.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. code 201.18(b)(2)(3) Management</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>37116</p> <p>Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for six of 30 residents reviewed (Residents 7, 25, 38, 39, 123, and 124).</p> <p>Findings include:</p> <p>Review of Resident 7's clinical record revealed diagnoses that included congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to meet your body's needs), chronic kidney disease (a condition characterized by a gradual loss of kidney function), and hypertension (high blood pressure).</p> <p>Interview with Resident 7 on July 15, 2024, at 12:30 PM, revealed he lost use of his leg when he was in the hospital, and he has been in therapy since he returned.</p> <p>Review of select documentation, titled Physical Therapy Evaluation, with a start of care date of May 21, 2024, revealed under section Range of Motion: does patient have limitation in lower extremity range of motion that interfered with daily function or placed resident at risk of injury in the last 7 days, it was noted impairment on one side. The document was signed by Employee 9 (Physical Therapist) on May 23, 2024.</p> <p>Review of Resident 7's Modification (02) of Medicare - 5 Day MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with ARD (assessment reference date- last day of the assessment period) of May 27, 2024, under section GG0115. Functional Limitation in Range of Motion. Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days, Lower extremity (hip, knee, ankle, foot) was marked no impairment.</p> <p>During an interview with the Director of Nursing (DON) on July 17, 2024, at 1:37 PM, the surveyor questioned the discrepancy between the question on the therapy evaluation and the question on the MDS.</p> <p>Follow-up interview with the DON July 18, 2024, at 10:28 AM, revealed the MDS was revised to reflect the lower extremity impairment on one side, and she would expect Resident 7's MDS to be coded accurately.</p> <p>Review of Resident 25's clinical record revealed diagnoses that included dementia (brain damage caused by multiple strokes which causes memory loss in older adults) and cerebral infarction (a stroke - damage to the brain from interruption of its blood supply).</p> <p>Review of Resident 25's Annual MDS Quarterly MDS with the ARD of February 1, 2024, revealed in Section N. Medications revealed that the Resident was not coded as receiving a hypnotic, an antibiotic, or an opioid, but was coded as receiving an anticoagulant.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 25's January and February 2024, Medication Administration Record (MAR) confirmed that the Resident had received a hypnotic (medication used to induce sleep), an antibiotic, and an opioid; and had not received an anticoagulant (medication used to prevent the formation of blood clots) during the assessment reference period.</p> <p>Review of Resident 25's second modification Quarterly MDS with an assessment reference date of May 27, 2024, revealed in Section N. Medications that the Resident was coded as not receiving a hypnotic.</p> <p>Review of Resident 25's May 2024, MAR revealed that the Resident had received a hypnotic during the assessment reference period.</p> <p>Email communication received from the DON on July 17, 2024, at 5:00 PM, indicated that Resident 25's MDS's were coded inaccurately and that a modification of the assessments had been completed.</p> <p>During an interview with the Nursing Home Administrator (NHA) and DON on July 18, 2024, at 10:43 AM, the DON confirmed that she would expect a resident's MDS's to be coded accurately.</p> <p>Review of Resident 38's clinical record revealed diagnoses that included type 2 diabetes mellitus (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), anxiety disorder (a feeling of worry, nervousness, or unease), and chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe).</p> <p>Review of Resident 38's Modification of Quarterly MDS with ARD of May 3, 2024, under section N. Medications, she was marked yes for receiving an anticoagulant.</p> <p>Review of Resident 38's physician orders in the timeframe of the ARD failed to reveal an anticoagulant medication was ordered.</p> <p>During an email correspondence with the NHA and DON on July 16, 2024, at 11:58 AM, the surveyor questioned the accuracy of Resident 38's MDS assessment.</p> <p>Interview with the DON on July 18, 2024, at 10:28 AM, revealed the assessment has been modified and she would expect Resident 38's MDS to be coded accurately.</p> <p>Review of Resident 39's clinical record revealed diagnoses that included included cerebral infarction (stroke - a brain injury caused by a lack of oxygen to a group of brain cells) and End Stage Renal Disease (condition where one's kidneys are functioning below 10 percent of their normal function).</p> <p>Review of facility incident report revealed that Resident 39 experienced a fall on July 4, 2024.</p> <p>Review of hospital discharge documents dated July 7, 2024, revealed that Resident 39 sustained a clavicle (collarbone) fracture as a result of her July 4, 2024 fall.</p> <p>Review of Resident 39's July 4, 2024, discharge-return-anticipated MDS revealed that this assessment was not coded to capture the fall with major injury that she experienced on July 4, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the DON on July 18, 2024, at 10:30 AM, she confirmed that Resident 39's July 4, 2024, MDS was inaccurate and was corrected.</p> <p>Review of Resident 123's clinical record revealed diagnoses that included congestive heart failure (weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues) and diabetes mellitus (condition results from insufficient production of insulin, causing high blood sugar).</p> <p>Review of Resident 123's nursing progress note dated June 2, 2024, revealed, Resident discharged home with her medications. She got picked up by her daughter.</p> <p>Review of Resident 123's June 2, 2024, discharge MDS revealed that it was coded to indicate that she was discharged to the hospital and not to her home.</p> <p>An email received from the NHA on June 18, 2024, at 12:58 PM, confirmed that Resident 123's discharge MDS was coded inaccurately and that it was corrected.</p> <p>Review of Resident 124's clinical record revealed diagnoses that included anxiety disorder (mental disorder characterized by feelings of worry about future events and/or fear in reaction to current events) and fracture of sacrum (break in the bone at the back of the pelvis).</p> <p>Review of Resident 124's nursing progress note dated April 26, 2024, revealed that she was transferred to the hospital at her request, and that her daughter later called back to the facility to inform that the Resident would not be returning.</p> <p>Review of Resident 124's April 26, 2024, discharge MDS revealed that the assessment was coded to indicate that Resident 124 was discharged home, and not to the hospital.</p> <p>An email received from the NHA on June 18, 2024, at 12:20 PM, confirmed that Resident 124's discharge MDS needed to be corrected to reflect that she was discharged to the hospital.</p> <p>28 PA. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49123</p> <p>Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure that a baseline care plan that included the minimum healthcare information necessary to properly care for a resident was developed and implemented within 48 hours of admission for one of 27 residents reviewed (Residents 378).</p> <p>Findings include:</p> <p>Review of Resident 378's clinical record revealed Resident 378 was admitted to the facility on [DATE], with diagnoses that included end stage renal disease (kidneys can no longer filter waste and excess fluids) and acute respiratory failure with hypoxia (not enough oxygen in the blood).</p> <p>During an interview on July 16, 2024 at 11:00 AM, with Resident 378, it was revealed that Resident 378 had a midline catheter and received dialysis treatment three times a week.</p> <p>Review of Resident 378's physician orders failed to document an order for hemodialysis or care needs surrounding hemodialysis.</p> <p>Review of Resident 378's baseline care plan failed to document hemodialysis and the required care surrounding dialysis.</p> <p>A staff interview on July 17, 2024 at 1:24 PM, with the Nursing Home Administrator and Director of Nursing (DON) revealed that hemodialysis and resident care surrounding dialysis should have been included in the baseline care plan. The DON stated it was the expectation of the facility that care plans be accurate.</p> <p>28 Pa. Code 211.12(d) Nursing Services</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>33879</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure the resident comprehensive plan of care accurately reflected the status of two of 27 residents reviewed (Residents 56 and 83).</p> <p>Findings include:</p> <p>Review of Resident 56's clinical record revealed diagnoses that included Alzheimer's disease (progressive, irreversible degenerative brain disease that results in decreased contact with reality and decreased ability to perform activities of daily living) and type two diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment).</p> <p>Review of Resident 56's physician orders revealed that on January 26, 2024, revealed Resident 56 was started on Rexulti (an atypical antipsychotic medication used to treat mental health disorders) 0.5 milligrams (mg - metric unit of measurement). On February 8, 2024, Resident 56's order for Rexulti was discontinued and Resident 56 was started on risperidone (antipsychotic medication used to treat mental health disorders) 0.25 mg once a day. On May 3, 2024, Resident 56's risperidone medication was increased with an additional 0.5 mg administered at bedtime.</p> <p>Review of Resident 56's comprehensive plan of care on July 17, 2024, at approximately 8:45 AM, revealed Resident 56 was not care planned for the use of an antipsychotic medication.</p> <p>During a staff interview on July 18, 2024, Director of Nursing (DON) revealed that Resident 56's comprehensive plan of care should have included a care plan for the use of an antipsychotic medication.</p> <p>Review of Resident 83's clinical record revealed diagnoses that included post-traumatic stress disorder (PTSD - a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event) and generalized anxiety disorder (condition that causes you to feel anxious about a wide range of situations and issues).</p> <p>Review of Resident 83's comprehensive plan of care revealed a focus area for PTSD. Further review of Resident 83's comprehensive plan of care failed to reveal that triggers were identified.</p> <p>A staff interview on July 18, 2024 at 10:53 AM, with the Nursing Home Administrator and the DON revealed Resident 83's PTSD triggers had been assessed and identified when Resident 83 was admitted in March 2023 and should have been listed on the comprehensive plan of care. The DON stated it was the facility's expectation that care plans be completed accurately.</p> <p>28 Pa code 211.12(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>46253</p> <p>Based on clinical record review, facility policy review, observation, and resident and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for four of 27 residents reviewed (Resident's 5, 40, 41, and 113).</p> <p>Finding include:</p> <p>Review of facility policy, titled SNF Clinical System Process - Care Plan, last reviewed April 24, 2024, read, in part, Updating & Revising the Care Plan: Including Resolving and Un-resolving the Focus, Goals, and Interventions - Care Plans will be updated and revised as needed. When and How Often: Based on ongoing assessment and evaluation of Patients needs and according to OBRA Requirements, Within 7 days of admission, at MDS interval, Quarterly review, with change in condition as it occurs.</p> <p>Review of Resident 5's clinical record revealed diagnoses that included vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults) and the presence of a gastrostomy tube (a surgically placed device used to give direct access to one's stomach for supplemental feeding, hydration or medicine).</p> <p>Observation of Resident 5 on July 15, 2024, at 9:46 AM, revealed a posting indicating that Resident 5 was on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes).</p> <p>Review of Resident 5's care plan failed to include enhanced barrier precautions as an intervention.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on July 17, 2024, at 1:12 PM, the DON indicated that she would look into the concern because she was not sure that the poster for Enhanced Barrier Precautions was for Resident 5.</p> <p>Email communication received from the DON on July 17, 2024, at 5:00 PM, indicated Resident 5 was on Enhanced Barrier Precautions because of their gastrostomy tube and their care plan had been updated.</p> <p>Review of Resident 40's clinical record revealed diagnoses that included urinary retention (inability to voluntarily empty the bladder [pass urine] completely or partially).</p> <p>Review of Resident 40's current physician orders revealed orders for an indwelling foley catheter (a flexible tube placed through the urethra to the bladder to drain urine), dated March 26, 2024; and an order for Enhanced Barrier Precautions related to urinary catheter, dated May 19, 2024.</p> <p>Email communication received from the DON on July 17, 2024, at 5:00 PM, indicated Resident 40 was on Enhanced Barrier Precautions because of their foley catheter and their care plan had been updated.</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>During an interview with NHA and DON on July 18, 2024, at 12:50 PM, the DON confirmed that Resident 5's and 40's care plan should have been updated before July 17, 2024, to reflect the implementation of Enhanced Barrier Precautions.</p> <p>Review of Resident 41's clinical record revealed diagnoses that included trigeminal neuralgia (chronic neurological condition that causes severe sudden pain on one side of the face) and morbid (severe) obesity due to excess calories (caused by consuming more calories than the body uses).</p> <p>During an interview with Resident 41 on July 16, 2024 at 9:50 AM, an observation was made of Resident 41 grimacing and moaning. Resident 41 revealed he had been dealing right sided facial pain for a while.</p> <p>Review of Resident 41's physician's progress notes revealed a note dated July 8, 2024, that stated Resident 41 has chronic difficult to control trigeminal neuralgia.</p> <p>Review of Resident 41's comprehensive plan of care failed to reveal a focus area or intervention for pain related to trigeminal neuralgia.</p> <p>A staff interview July 18, 2024 at 10:57 AM, with the NHA and DON, revealed Resident 41's comprehensive plan of care had been revised to include pain due to trigeminal neuralgia. The DON stated that it was the facility's expectation care plan revisions be timely.</p> <p>Review of Resident 113's clinical records revealed diagnoses that included short bowel syndrome (condition that occurs when the small is damaged preventing absorption of nutrients from food) and protein-calorie malnutrition (nutritional state where the body doesn't get enough protein, calories, or other nutrients causing changes in body composition and function).</p> <p>Review of Resident 113's physician orders revealed an order for a left double lumen PICC (peripherally inserted central catheter): inserted June 21, 2024, at 2:58 PM.</p> <p>Review of Resident 113's comprehensive plan of care failed to reveal a focus area or interventions for a PICC line.</p> <p>A staff interview July 18, 2024 at 1:28 PM, with the NHA and DON, revealed Resident 113's comprehensive plan of care had been revised. The DON stated that it was the facility's expectation care plan revisions be timely.</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46253</p> <p>Based on facility policy review, observations, clinical record review, and staff interview, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards for one of 27 residents reviewed (Resident 5).</p> <p>Findings Include:</p> <p>Review of facility policy, titled 5.3 Storage and Expiration Dating of Medications, Biologicals, with a last revision date of August 7, 2023, and last review date of April 24, 2024, revealed 13. Bedside Medication Storage: 13.1 Facility should not administer/provide bedside medications or biologicals without a Physician/Prescriber order and approval by the Interdisciplinary Care Team and Facility administration; and 13.2 Facility should store bedside medications or biologicals in a locked compartment within the resident's room.</p> <p>Review of Resident 5's clinical record revealed diagnoses that included vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults), cognitive communication deficit (difficulty in thinking and how someone uses language), and muscle contractures (condition of shortening and hardening of muscles, tendons, or other tissue often leading to deformity and rigidity of joints).</p> <p>Review of Resident 5's current physician orders revealed orders for Ammonium Lactate Cream 12 % [a prescription medication is used to treat dry, scaly skin conditions] apply to BLE [bilateral lower extremities] topically every day shift for dry skin, dated September 28, 2022; and OcuSoft Lid Scrub Plus External Pad (Eyelid Cleanser) apply to both eyes topically every day shift for health maintenance, dated December 17, 2022.</p> <p>Observations of Resident 5 on July 15, 2024, at 9:48 AM, and July 16, 2024, at 8:47 AM, revealed that there was an opened box of individually wrapped Ocusoft lid scrubs and two tubes of Ammonium Lactate at their bedside.</p> <p>Further review of Resident 5's clinical record failed to reveal an order that medications could be stored at bedside and that Resident 5 was unable to administer/utilize the Ocusoft Lid Cleanser, or the Ammonium Lactate independently based on their current physical and mental status.</p> <p>During an interview with the Nursing Home Administrator and Director of Nursing (DON) on July 17, 2024, at 1:13 PM, the DON indicated that these medications were prescribed medications and should not have been kept at the bedside.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(2) 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 - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>49123</p> <p>Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure each resident received treatment in accordance with professional standards of practice for two of 27 residents reviewed (Residents 113 and 378).</p> <p>Findings Include:</p> <p>Review of Resident 113's clinical records revealed diagnoses that included acute renal failure (ARF - a sudden and often reversible decrease in kidney function), short bowel syndrome (condition that occurs when the small is damaged preventing absorption of nutrients from food), and protein-calorie malnutrition (nutritional state where the body doesn't get enough protein, calories, or other nutrients causing changes in body composition and function).</p> <p>Review of Resident 113's physician orders revealed an order for a left double lumen PICC (peripherally inserted central catheter): inserted June 21, 2024 at 2:58 PM. Further review of Resident 113's physician orders revealed no orders for monitoring Resident 113's PICC line site and PICC line site dressing changes.</p> <p>Review of Resident 113's physician progress notes revealed a note dated June 6, 2024, at 10:32 AM, that stated, Admission History and Physical - Will continue other medications. Continue providing supportive care. Monitor labs as needed. Discussed with the patient and nursing staff. Patient is DNR (do not resuscitate).</p> <p>Further review of Resident 113's clinical record revealed no physician's order for staff to carry out Resident 113's wishes in the event of cardiopulmonary arrest.</p> <p>An interview on July 17, 2024 at 1:27 PM, with the Nursing Home Administrator (NHA) and Director of Nursing (DON), revealed orders for PICC line site monitoring and care and code status had been entered. The DON stated it was the expectation of the facility that orders would have been in place.</p> <p>Review of Resident 378's clinical record revealed diagnoses that included end stage renal disease (kidneys can no longer filter waste and excess fluids) and acute respiratory failure with hypoxia (not enough oxygen in the blood).</p> <p>During an interview on July 16, 2024 at 11:00 AM, with Resident 378 it was revealed that Resident 378 had a midline catheter and received dialysis treatment three times a week.</p> <p>Review of Resident 378's current physician orders revealed orders for check bruit and thrill at AV fistula (surgically created connection between an artery and a vein that provided access for hemodialysis) site every shift and alert charting: dialysis three times per week - skin, PO intake, site, tolerance every shift for monitoring. Further review of Resident 378's orders revealed no orders for dialysis treatment or dialysis access site care.</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>During an interview on July 17, 2024, at 1:24 PM, with the NHA and DON, the DON confirmed that Resident 378 has a midline catheter for dialysis treatment. The DON stated that orders for dialysis treatment and dialysis access site monitoring and care had been added. The DON also stated that it was the expectation of the facility that orders be accurate and in place.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident Care Policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>48484</p> <p>Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure residents with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one of four residents reviewed for limited range of motion (Resident 115).</p> <p>Findings include:</p> <p>Review of Resident 115's clinical record revealed diagnoses that included encounter for orthopedic aftercare (aftercare following joint replacement surgery), hereditary and idiopathic neuropathy (a group of inherited disorders that affect the peripheral nervous system), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things).</p> <p>Interview with Resident 115 on July 15, 2024, at 10:12 AM, revealed he had previously received therapy services, but he doesn't get out of bed much since then.</p> <p>Review of select documentation, titled Physical Therapy Discharge Summary, signed by Employee 5 (Physical Therapist) on March 22, 2024, revealed Discharge reason, maximum potential achieved, refer to restorative nursing program/functional maintenance program.</p> <p>Further review of the aforementioned document further revealed Discharge Recommendations: Assistive device for safe functional mobility. Home exercise program and restorative nursing program. Patient is moderate 1 [assist] with transfers. Patient to ambulate with nursing 50 feet with rolling walker supervised on restorative ambulation program.</p> <p>Review of Resident 115's clinical record, including his care plan, failed to reveal notation of a restorative nursing program.</p> <p>During an interview with the Director of Nursing (DON) on July 17, 2024, at 1:39 PM, the surveyor requested information about Resident 115's restorative nursing program including documentation of minutes captured.</p> <p>Follow-up interview with the DON on July 17, 2024, at 10:25 AM, revealed she could not find any documentation to indicate the restorative nursing program had been implemented and confirmed that it was a recommendation from therapy. No further information was provided.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>37116</p> <p>Based on observations, policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure residents received appropriate treatment and services to prevent urinary tract infections and complications related to the use of a foley catheter (small, flexible tube that can be inserted through the urethra and into the bladder, allowing urine to drain) for two of two residents reviewed for catheter use (Residents 12 and 40).</p> <p>Findings Include:</p> <p>Review of facility policy, titled Catheter: Indwelling Urinary - Care Of, revised February 1, 2023, revealed, Secure the catheter tubing to keep the drainage bag below the level of the resident's bladder and off the floor.</p> <p>Review of Resident 12's clinical record revealed diagnoses that included malignant neoplasm of bladder (bladder cancer) and retention of urine.</p> <p>Observations on July 15, 2024, at 10:14 AM and at 10:49 AM, revealed Resident 12 had a urinary catheter, and the catheter drainage bag was laying on the floor next to her bed, doubled over onto itself.</p> <p>When informed of the concern at 10:52 AM, Employee 6 (Licensed Practical Nurse) placed a cover on Resident 12's catheter bag and reattached it to the bed.</p> <p>During an interview with the Director of Nursing (DON) on July 18, 2024, at 10:56 AM, she confirmed that Resident 12's catheter bag should have been covered and not touching the floor.</p> <p>Review of Resident 40's clinical record revealed diagnoses that included urinary retention (inability to voluntarily pass urine completely or partially).</p> <p>Observations of Resident 40 on July 15, 2024, at 12:30 PM, and July 17, 2024, at 9:01 AM, revealed that the Resident was up in their wheelchair in the lounge, and their urinary catheter tubing was touching/resting on the floor.</p> <p>During an interview with the Nursing Home Administrator and the DON on July 18, 2024, at 10:43 AM, the DON indicated that Resident 40's catheter tubing should not have been touching or resting on the floor.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</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>Provide enough food/fluids to maintain a resident's health.</p> <p>48484</p> <p>Based on facility policy review, observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to monitor hydration status precisely and effectively for one of 27 residents reviewed (Resident 7).</p> <p>Findings include:</p> <p>Review of facility policy, titled Nutrition/Hydration Care and Services, last revised February 1, 2023, read, in part, Practice Standards: Maintain fluid and hydration balance. When a physician orders a fluid restriction due to specific clinical condition, dietary will calculate the amount of fluids to be provided on the meal trays, nursing will calculate the remaining amounts of fluids allotted for each shift. Inform the patient and/or patient representative of fluid restriction.</p> <p>Review of Resident 7's clinical record revealed diagnoses that included congestive heart failure (CHF - a long-term condition that happens when your heart can't pump blood well enough to meet your body's needs), chronic kidney disease (CKD - a condition characterized by a gradual loss of kidney function), and hypertension (high blood pressure).</p> <p>Review of Resident 7's physician orders revealed an order: Monitor Daily Fluid Restriction Total 1800ml (milliliter-unit of measure): Breakfast tray 300 ml; free fluids Day shift 480ml; Lunch tray 240 ml; free fluids Evening Shift 240 ml; Dinner tray 480 ml; free fluids Night Shift 60 ml; every shift, with a start date of June 27, 2024.</p> <p>Observation in Resident 7's room on July 15, 2024, at 12:33 PM, revealed he had a 900 ml mug full of ice water, and a 600 ml bottle of soda about half full on his bedside table.</p> <p>Observation in Resident 7's room on July 16, 2024, at 11:39 AM, revealed he had a 900 ml mug half full of ice water and a 600 ml bottle of soda about a quarter full on his bedside table.</p> <p>During an interview with Resident 7's room on July 16, 2024, at 11:40 AM, he revealed he thought he was on a fluid restriction, but he is not sure why he is on one or how it is managed, and he enjoys having one or two soda's a week.</p> <p>Interview with Employee 1 (Nurse Aide) on July 16, 2024, at 11:42 AM, she revealed she was not Resident 7's aide that day, but when she is his aide, she goes by the fluid restriction guide at the nurse's station and pointed to the document.</p> <p>Observation of the aforementioned document on July 16, 2024, at 11:43 AM, revealed it was a chart for a 1200 ml fluid restriction, with guidelines to provide 600 ml fluids on day shift, 500 ml of fluids on evening shift, and 100 ml of fluids on night shift.</p> <p>Observation in Resident 7's room on July 16, 2024, at 12:14 PM, revealed he had his lunch tray with 120 ml cranberry juice; the mug of ice water and soda remained on his bedside table.</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 Resident 7's care plan revealed a nutrition focused care plan with an intervention for no water pitcher in room, with a start date of June 27, 2024.</p> <p>Review of Resident 7's dietary meal tickets from July 16, 2024, revealed notation that dietary provided 540 ml total fluids at breakfast, 120 ml fluids at lunch, and 480 ml fluids at dinner.</p> <p>Review of Resident 7's clinical record revealed a nutrition progress note on July 16, 2024, at 3:33 PM, that stated 1800ml fluid restriction breakdown clarified: Total 1800ml: 1080ml dietary: 360ml/meal; 720ml total for nursing medication pass: 360ml AM, 240ml PM, 120ml HS. Meal ticket updated and dietary aware.</p> <p>Review of Resident 7's physician orders revealed an order Monitor Daily Fluid Restriction Total 1800ml: 1080ml dietary: 360ml/meal, 720ml total for nursing med pass: 360ml AM, 240ml PM, 120ml bedtime, every shift, with a start date of July 16, 2024, at 3:00 PM.</p> <p>Interview with Employee 7 (Dietary Manager) on July 17, 2024, at 12:16 PM, the surveyor inquired about the fluid restriction clarification. Employee 7 revealed he believed it was because the wrong amount of fluids were being provided from dietary at breakfast.</p> <p>Observation of Resident 7's in his room on July 17, 2024, at 12:19 PM, revealed he had a 900 ml mug of ice water about half full and a 120 ml cranberry juice on his lunch tray.</p> <p>Interview with Employee 2 (Licensed Practical Nurse) on July 17, 2024, at 12:23 PM, revealed she only provides Resident 7 with 120 ml of fluid with his morning medication pass, and that Employee 3 (Nurse Aide) filled his water mug that morning. She further revealed he only has one medication at lunchtime, so she gives it to him without additional fluids and he sips out of his mug.</p> <p>Review of Resident 7's dietary meal tickets from July 17, 2024, revealed they noted to provide the same amount of fluids as the ones reviewed from July 16, 2024.</p> <p>During an interview with the Director of Nursing (DON) on July 17, 2024, at 1:37 PM, the surveyor revealed the concern with the overall management of Resident 7's fluid restriction, including that the order that was updated on July 16, 2024, remained to not match the fluids provided on his tray tickets on July 16 and 17, 2024.</p> <p>Follow up interview with the DON on July 18, 2024, at 10:28 AM, revealed Resident 7 does not wish to comply with a fluid restriction so they have a note in to the doctor to see if it could be discontinued.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>37116</p> <p>Based on observations, clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to ensure respiratory care was provided in a manner consistent with professional standards of practice for three of five residents reviewed for respiratory care (Residents 41, 54, and 84).</p> <p>Findings include:</p> <p>Review of facility policy, Respiratory Equipment/Supply Cleaning/Disinfecting, revised July 15, 2021, revealed, Oxygen Concentrators: Rinse and dry the external filter weekly and PRN [as-needed] when visibly dusty and change oxygen delivery devices-every seven days and as needed for soiling.</p> <p>Review of Resident 41's clinical record revealed diagnoses that included respiratory failure with hypercapnia (when the lungs have difficulty removing carbon dioxide from the blood) and morbid (severe) obesity with alveolar hypoventilation (diminished respiratory drive related to obesity).</p> <p>Observations made on July 16, 2024, at 9:43 AM, and July 17, 2024, at 1:09 PM, revealed Resident 41 receiving supplemental oxygen via nasal canula. No date was noted on Resident 41's nasal canula tubing. Additional tubing that connected the humidification bottle was dated June 28, 2024.</p> <p>Review of Resident 41's physician orders revealed an order that stated oxygen tubing change weekly label each component with date and initials, every night shift, every Sunday for infection control.</p> <p>During a staff interview July 18, 2024, at 10:50 AM, with the Nursing Home Administrator (NHA) and Director of Nursing (DON), the DON stated it was the expectation of the facility that oxygen tubing be changed weekly and dated.</p> <p>Review of Resident 54's clinical record revealed diagnoses that included vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults) and chronic obstructive pulmonary disease (COPD-a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitations).</p> <p>Observations of Resident 54 on July 15, 2024, at 9:40 AM; July 16, 2024, at 9:45 AM, and July 17, 2024, at 8:49 AM, revealed that the Resident was receiving supplemental oxygen via nasal cannula. The tubing was not dated and there was a clear storage bag noted on the concentrator dated 6/23. In addition, a portable oxygen cylinder was noted to be stored on the back of Resident 54's wheelchair with a nasal cannula and tubing attached that was wrapped around the handle of the wheelchair that was not dated.</p> <p>Review of Resident 54's current physician orders revealed orders for oxygen 2 liters per nasal cannula as needed to maintain an oxygen saturation of 90% or greater dated May 4, 2024; and check oxygen saturation level every shift dated June 19, 2024.</p> <p>Further review of Resident 54's current physician orders failed to reveal any orders for the changing of their oxygen tubing.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 54's July Medication Administration Record (MAR) failed to reveal documentation that the Resident had received oxygen on July 15, 16, or 17, 2024, as was observed.</p> <p>Further review of Resident 54's July 2024 MAR revealed that staff were obtaining their oxygen saturation level, but there was no documentation to reflect the use of oxygen.</p> <p>Email communication received from the DON on July 17, 2024, at 5:00 PM, revealed that Resident 54's oxygen orders had been corrected, their tubing had been replaced, and that the storage bag was also replaced.</p> <p>During an interview with the DON on July 18, 2024, at 10:40 AM, the DON confirmed that the tubing should have been changed and dated according to policy and that staff should be documenting the administration of oxygen to Resident 54.</p> <p>Review of Resident 84's clinical record revealed diagnoses that included emphysema (lung condition that causes shortness of breath) and chronic respiratory failure (condition where the lungs cannot provide enough oxygen or remove enough carbon dioxide from the blood).</p> <p>Review of Resident 84's current physician orders revealed an order for continuous supplemental oxygen use a 2 L (Liters) per hour, effective May 28, 2024.</p> <p>Observation on July 15, 2024, at 10:32 AM, revealed Resident 84 was utilizing supplemental oxygen. Observation of her oxygen concentrator's filter revealed it was covered in a layer of gray, fuzzy debris.</p> <p>During an interview with Employee 6 (Licensed Practical Nurse) on July 15, 2024, at 10:53 AM, she confirmed that the filter needed to be cleaned. She stated that she would inquire about the current process for doing so.</p> <p>Additional observations made on July 16, 2024, at 2:01 PM, and on July 17, 2024, at 12:52 AM, revealed Resident 84's oxygen concentrator filter remained covered in a layer of gray, fuzzy debris.</p> <p>During an interview with the DON on July 18, 2024, at 10:30 AM, she confirmed that the filter was cleaned and replaced. She revealed that it should be have been cleaned as part of the weekly cleaning and maintenance process.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>33879</p> <p>Based on clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to ensure pharmacy recommendations were appropriately acted upon for four of five residents reviewed for unnecessary medications (Resident 7, 25, 54, and 56), and one of one resident reviewed for insulin use (Resident 51).</p> <p>Findings include:</p> <p>Review of facility policy, titled Psychotropic Medication Use, Last revised October 24, 2022, revealed section two of Procedure, stated, Facility should comply with the Psychopharmacologic Dosage Guidelines created by the Centers for Medicare and Medicaid Services ('CMS'), the State Operations Manual, and all other Applicable Law relating to the use of psychopharmacologic medications including gradual dose reductions.</p> <p>Review of facility policy, titled Medication Regimen Review (MRR), last revised June 1, 2024, read, in part, Facility should alert the medical director where MRRs are not addressed by the attending physician in a timely manner. The facility should encourage physician/prescriber or other responsible parties receiving the MRR and the director of nursing to act upon the recommendations contained in the MRR. The attending physician/prescriber should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident, per facility policy and state or federal regulations.</p> <p>Review of Resident 7's clinical record revealed diagnoses that included congestive heart failure (CHF - a long-term condition that happens when your heart can't pump blood well enough to meet your body's needs), chronic kidney disease (CKD - a condition characterized by a gradual loss of kidney function), and hypertension (high blood pressure).</p> <p>Review of Resident 7's physician orders revealed an order for Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)) Apply to left shoulder topically every day and evening shift for left shoulder pain, with a start date of May 7, 2024, and discontinued on May 13, 2024, noting it was discontinued because he was admitted to the hospital.</p> <p>Further review of Resident 7's physician orders revealed an order for Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)) Apply to left shoulder topically every day and evening shift for left shoulder pain, with a start date of May 21, 2024.</p> <p>Review of the pharmacist medication regimen review document provided from May 9, 2024, revealed a recommendation for the diclofenac gel order to be updated to include a specified amount of grams (unit of measure) of gel to apply.</p> <p>Further review of the pharmacist medication regimen review document from May 9, 2024, revealed the physician commented that the medication was discontinued at the time as the Resident was in the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Additional copy of the medication regimen review provided revealed it had notation that Resident 7 was in the hospital from May 12 to 20, 2024, and that the medication was reordered with the location upon readmission. It was not signed by a physician and the order had not been updated to include the pharmacy recommendation.</p> <p>During an interview with the Director of Nursing (DON) on July 17, 2024, at 1:35 PM, the surveyor questioned the response to the May 9, 2024, pharmacy recommendation.</p> <p>Follow-up interview with the DON on July 18, 2024, at 12:50 PM, revealed the order had been updated to include grams to apply per the pharmacy recommendation, and she would expect pharmacy reviews to be reviewed and responded to timely by the physician.</p> <p>Review of Resident 25's clinical record revealed diagnoses that included dementia (brain damage caused by multiple strokes which causes memory loss in older adults) and cerebral infarction (a stroke: damage to the brain from interruption of its blood supply).</p> <p>Review of Resident 25's clinical record revealed that the consultant pharmacist had reviewed their medication regimen and made recommendations on November 28, 2023.</p> <p>Review of the facility provided pharmacy recommendation report for Resident 25 dated November 28, 2023, revealed that the recommendation was to review their use of zolpidem (medication used to promote a restful night's sleep) for a gradual dose reduction. There was a note written on this facility provided report that indicated they could not locate the original report that would have been reviewed and signed by Resident 25's physician, but that the medication was discontinued on December 31, 2023.</p> <p>Further review of Resident 25's clinical record revealed that the consultant pharmacist had reviewed their medication regimen and made recommendations on May 14, 2024.</p> <p>Review of the facility provided pharmacy recommendation report for Resident 25 dated May 14, 2024, revealed that the recommendation was to review their use of olanzapine (medication used to treat psychiatric disorders) for a gradual dose reduction. There was a note written on this facility provided report that indicated they could not locate the original report that would have been reviewed and signed by Resident 25's physician and that there was no gradual dose reduction completed for the medication.</p> <p>During an interview with the Nursing Home Administrator (NHA) and DON on July 18, 2024, at 10:43 AM, the DON confirmed that Resident 25's pharmacy recommendations should have been responded to in a timely manner and that the facility should maintain copies of such in the resident's clinical record.</p> <p>Review of Resident 51's clinical record revealed diagnoses that included type two diabetes mellitus with hyperglycemia (high blood sugar due to the body not producing or using insulin properly) and morbid (severe) obesity due to excess calories (caused by consuming more calories than the body uses).</p> <p>Review of Resident 51's monthly pharmacy reviews revealed that on June 20, 2024, a recommendation was made by the pharmacist.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During staff interviews with the NHA and DON on July 16, 2024, at 1:14 PM, and July 17, 2024, at 1:46 PM, the surveyor requested a copy of the pharmacy recommendation made on June 20, 2024. The facility failed to provide a copy of the pharmacy recommendation.</p> <p>A staff interview on July 18, 2024, at 10:50 AM, with the NHA and DON it was revealed that the pharmacy recommendation had been located, but had not been addressed and had now been placed in the physician's folder for review. The DON stated it was the expectation of the facility that pharmacy recommendations be responded to in a timely manner.</p> <p>Review of Resident 54's clinical record revealed diagnoses that included vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults) and osteoarthritis (degeneration of joint cartilage and the underlying bone, causing pain and stiffness especially in the hip, knee, and thumb joints).</p> <p>Review of Resident 54's clinical record revealed that the consultant pharmacist had reviewed their medication regimen and made recommendations on April 19, 2024, and May 12, 2024.</p> <p>Review of the facility provided pharmacy recommendation report for Resident 54 dated April 19, 2024, revealed that the recommendation was to review their order for ibuprofen be discontinuation due to non-use. There was a note written on this facility provided report that indicated they could not locate the original report that would have been reviewed and signed by Resident 54's physician.</p> <p>Review of the facility provided pharmacy recommendation report for Resident 54 dated May 12, 2024, revealed that the recommendation was again to review their order for ibuprofen for discontinuation due to non-use. There was documentation by Resident 54's physician that indicated to DC [discontinue] and was signed, not dated, and contained a notation by the physician that indicated Hosp [hospital].</p> <p>Review of Resident 54's physician order history revealed that their ibuprofen order was discontinued on June 27, 2024.</p> <p>During an interview with the NHA and DON on July 18, 2024, at 10:43 AM, the DON confirmed that Resident 25's pharmacy recommendations should have been responded to in a timely manner and that the facility should maintain copies of such in the resident's clinical record.</p> <p>Review of Resident 56's clinical record revealed diagnoses that included Alzheimer's disease (progressive, irreversible degenerative brain disease that results in decreased contact with reality and decreased ability to perform activities of daily living) and type two diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment).</p> <p>Review of Resident 56's physician orders revealed that on January 26, 2024, Resident 56 was started on Rexulti (an atypical antipsychotic medication used to treat mental health disorders) 0.5 milligrams (mg - metric unit of measurement). On February 8, 2024, Resident 56's order for Rexulti was discontinued and Resident 56 was started on risperidone (antipsychotic medication used to treat mental health disorders) 0.25 mg once a day. On May 3, 2024, Resident 56's risperidone medication was increased with an additional 0.5 mg administered at bedtime.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the risperidone orders revealed the indication for use was documented as agitation and depression.</p> <p>Review of a pharmacy recommendation dated March 23, 2024, revealed the consultant pharmacist recommended a gradual dose reduction of the risperidone due to increased risk for stroke and mortality in those with dementia-related psychosis.</p> <p>Review of the recommendation revealed that the physician declined the recommendation and provided a rationale that stated, [Resident] needs.</p> <p>However, review of Resident 56's interdisciplinary progress notes for one year prior to March 23, 2024, revealed staff documented Resident 56 experiencing hallucinations once on August 22, 2023, and combative behavior with staff four times: August 29 and 30, 2023; January 19, 2024; and February 9, 2024.</p> <p>Review of the clinical record revealed no clinical rationale provided for the refusal of a gradual dose reduction for Resident 56, nor was there documentation that showed Resident 56 should not receive a gradual dose reduction of the antipsychotic medication.</p> <p>During a staff interview on July 18, 2024, at approximately 10:50 AM, the DON confirmed that there was not an appropriate clinical rationale provided in declining the recommendation for a gradual dose reduction for Resident 56.</p> <p>28 Pa. code 211.9 (a)(1) Pharmacy services</p> <p>28 Pa. Code 211.12(c)(d)(3)(5) Nursing services</p>		

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NAME OF PROVIDER OR SUPPLIER Carlisle Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 940 Walnut Bottom Road Carlisle, PA 17013	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>33879</p> <p>Based on clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to ensure the resident medication regimen was free of unnecessary psychotropic medications for two of five residents reviewed for unnecessary medications (Residents 25 and 56).</p> <p>Findings include:</p> <p>Review of facility policy, titled Psychotropic Medication Use, last revised October 24, 2022, revealed section 10 of Procedure, stated, All medication used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors should be monitored for .efficacy .</p> <p>Review of Resident 25's clinical record revealed diagnoses that included dementia, anxiety, and depression.</p> <p>Review of Resident 25's current physician orders revealed that the Resident was receiving the following psychotropic medications: belsomra (medication used to treat difficulty falling and staying asleep) oral tablet 10 mg (milligrams) give one tablet by mouth at bedtime for insomnia, dated March 2, 2024; lorazepam (a medication used to treat anxiety) oral tablet 0.5 mg give one tablet by mouth two times a day for anxiety, dated April 5, 2023; olanzapine (an antipsychotic medication used to treat psychiatric disorders) oral tablet 5 mg give 5 mg by mouth at bedtime for Major Depressive Disorder (MDD), dated April 5, 2023; and venlafaxine (medication used to treat depression) oral tablet Extended Release 24 Hour 150 mg give 150 mg by mouth two times a day for MDD, dated April 5, 2023. In addition, there was an order for Vital Health to evaluate and treat for psychiatric services, dated April 5, 2023.</p> <p>Review of Resident 25's clinical record revealed that the consultant pharmacist had reviewed their medication regimen and made recommendations on November 28, 2023.</p> <p>Review of the facility provided pharmacy recommendation report for Resident 25 dated November 28, 2023, revealed that they were receiving zolpidem, venlafaxine, olanzapine, and lorazepam and to review listed medications and consider a gradual dose reduction. The recommendation also stated to review zolpidem for a gradual dose reduction. There was a note written on this facility provided report that indicated they could not locate the original report that would have been reviewed and signed by Resident 25's physician, but that the zolpidem was discontinued on December 31, 2023.</p> <p>Review of the facility provided pharmacy recommendation report for Resident 25 dated May 14, 2024, revealed that the recommendation was to review their use of olanzapine (medication used to treat psychiatric disorders) for a gradual dose reduction. There was a note written on this facility provided report that indicated they could not locate the original report that would have been reviewed and signed by Resident 25's physician and that there was no gradual dose reduction completed for the medication.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on July 17, 2024, at 1:20 PM, it was discussed that Resident 25 had an order for the in-house provider for psychiatric services, but clinical record review failed to reveal any visit notes. The NHA indicated that Resident 25 sees their psychiatrist in the community.</p> <p>Review of facility provided psychiatric visit notes revealed a note dated July 31, 2023, which indicated that the Resident had a telehealth visit and that recommendation was to continue all psychotropic medications as ordered.</p> <p>Review of Resident 25's clinical record progress note revealed a social service note dated March 12, 2024, at 10:50 AM, that indicated they had spoken to Resident 25's responsible party about reaching out to their therapist and setting up a telehealth therapy appointment. The note further indicated that the responsible party indicated they would reach out to set up the appointment, but also shared that this physician had said that they could not treat Resident 25 because they were in a skilled nursing facility.</p> <p>Review of follow-up social services note dated March 12, 2024, at 12:00 PM, indicated that Resident 25's family had set up a therapy appointment on March 25, 2024, at 2:40 PM.</p> <p>Further review of Resident 25's clinical record failed to reveal any psychiatric visit notes from the March 25, 2024, appointment.</p> <p>During an interview with the NHA and the DON on July 18, 2024, at 10:43 AM, the DON confirmed that the missing recommendations were for review of Resident 25's psychotropic medication usage for possible gradual dose reductions and, therefore, they could not show evidence that their psychotropic medications had been reviewed.</p> <p>As of July 18, 2024, at 2:15 PM, the facility had provided no additional documentation for review.</p> <p>Review of Resident 56's clinical record revealed diagnoses that included Alzheimer's disease (progressive, irreversible degenerative brain disease that results in decreased contact with reality and decreased ability to perform activities of daily living) and type two diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment).</p> <p>Review of Resident 56's physician orders revealed that on January 26, 2024, Resident 56 was started on Rexulti (an atypical antipsychotic medication used to treat mental health disorders) 0.5 milligrams (mg - metric unit of measurement). On February 8, 2024, Resident 56's order for Rexulti was discontinued and Resident 56 was started on risperidone (antipsychotic medication used to treat mental health disorders) 0.25 mg once a day. On May 3, 2024, Resident 56's risperidone medication was increased with an additional 0.5 mg administered at bedtime. Review of the risperidone orders revealed the indication for use was documented as agitation and depression.</p> <p>Review of Resident 56's clinical record revealed no monitoring of target behaviors for the use of an antipsychotic for Resident 56.</p> <p>Review of Resident 56's comprehensive plan of care revealed resident 56 was not care planned for the use of an antipsychotic medication.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 56's interdisciplinary progress notes for one year prior to March 23, 2024, revealed staff documented Resident 56 experiencing hallucinations once on August 22, 2023, and combative behavior with staff four times, August 29 and 30, 2023; January 19, 2024; and February 9, 2024.</p> <p>During a staff interview on July 18, 2024, DON confirmed that there was no targeted behavior tracking in place for Resident 56 for the use of an antipsychotic medication prior to July 17, 2024. During the interview, DON stated there should have been monitoring for target behaviors in place.</p> <p>28 Pa Code 201.18(b)(1) Management</p> <p>28 Pa Code 211.5(f)(ii) Medical records</p> <p>28 Pa Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa Code 211.12(c)(d)(1)(2)(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 - Some</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>49123</p> <p>Based on observations, facility policy review, and staff interview, it was determined that the facility failed to place opened dates on medications in two of three medication carts observed (100 Hall and 200 Hall).</p> <p>Findings Include:</p> <p>Review of facility policy, titled 5.3 Storage and Expiration Dating of Medication, Biologicals, last reviewed April 24, 2024, read, in part, This Policy 5.3 sets forth the procedures relating to the storage and expiration dates of medication, biologicals, syringes, and needles. Procedure 5. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dated for opened medication. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened.</p> <p>Observation of the 200 hall medication cart on July 17, 2024, at 9:01 AM, revealed open stock bottles of the following medications with no open date: stool softener 100 mg, chewable aspirin 81 mg, delayed release aspirin 81 mg, vitamin D3 25 mcg/1000IU, and ibuprofen 200 mg.</p> <p>A staff interview on July 17, 2024, at 9:01 AM, with Employee 8 revealed he was not sure if stock bottles of medication needed to be dated when opened.</p> <p>Observation of the 100 hall medication care on July 17, 2024, at 9:29 AM, revealed open stock bottles of the following medications with no open date: stool softener 100 mg, chewable aspirin 81 mg, delayed release aspirin 81 mg, vitamin D3 25 mcg, and diphenhydramine 25 mg.</p> <p>A staff interview on July 17, 2024, at 9:29 AM, with Employee 6 revealed she was not sure if stock bottles of medication needed to be dated when opened.</p> <p>During a staff interview on July 18, 2024 at 1:15 PM, with the Nursing Home Administrator and Director of Nursing (DON), The DON stated that it was the facility's expectation that stock medication bottles be dated when opened.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services</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>48484</p> <p>Based on facility policy reviews, observations, and staff interview, it was determined that the facility failed to store food and utilize equipment in accordance with professional standards for food service safety in the main kitchen and three of three nourishment areas</p> <p>Findings include:</p> <p>Review of facility policy, titled Refrigerated/Frozen Storage, dated May 1, 2023, read, in part, Food stored under refrigeration/freezer storage is maintained in a safe and sanitary manner. Purpose: to prevent damage, spoilage, and contamination of products. All foods are labeled with the name of product and the date received and 'use by' date one opened. Manufacturer 'use by' dates are used until opened. Food and Nutrition Services employees observe and record equipment temperatures daily according to the Refrigerator/Freezer Temperature Standards.</p> <p>Review of facility policy, titled Food and Nutrition Services 'use by' dating guidelines, dated July 10, 2023, read, in part, Item: produce and thickened liquids, date with 'use by' date seven days after opening. Frozen food stored in the freezer, 'use by' date of 45 days after opening and properly closed.</p> <p>Observation in the main kitchen on July 15, 2024, at 9:05 AM, revealed a shelf containing four packs of wheat bread labeled use by July 12, 2024; a shelf containing two packs of hoagie rolls not dated; and a shelf containing four packs of white bread not dated.</p> <p>Observation in the walk-in freezer on July 15, 2024, at 9:12 AM, revealed: one bin of sauerkraut labeled use by June 3, 2024, and not sealed properly; one container of cinnamon rolls left open to air; one bin of English muffins labeled use by June 15, 2024; one box of diced carrots left open to air; one bin of pineapple sauce labeled use by June 24, 2024; one bin of ziti not dated and not sealed properly; one bin of ground pork labeled use by June 14, 2024, and not sealed properly; one bin of pureed vegetables labeled use by June 15, 2024; one bin of chili labeled use by June 17, 2024; and one bin of chicken pot pie labeled use by June 19, 2024.</p> <p>Observation in the walk-in refrigerator on July 15, 2024, at 9:15 AM, revealed one bag of spinach not dated and it was mostly wilted.</p> <p>Observation of the dry storage area in the main kitchen on July 15, 2024, at 9:17 AM, revealed two bags of puffed rice cereal not dated; and one bag of elbow noodles open and not dated with an open date.</p> <p>Observation of reach in refrigerator 1 on July 15, 2024, at 9:19 AM, revealed one bag of bologna labeled use by July 12, 2024.</p> <p>Observation of reach in refrigerator 2 on July 15, 2024, at 9:21 AM, revealed three containers of pureed chicken labeled use by July 14, 2024; and one bag of turkey labeled use by July 12, 2024.</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 in the west pantry area on July 15, 2024, at 9:26 AM, revealed three bins of snacks labeled use by July 12, 2024.</p> <p>Observation in the west pantry area refrigerator on July 15, 2024, at 9:27 AM, revealed one container of thickened orange juice open without an open date.</p> <p>Observation of the July 2024, west pantry area refrigerator temperature log on July 15, 2024, at 9:28 AM, failed to reveal temperatures logged on July 2 and 12, 2024; the refrigerator was 70 degrees on July 6, and out of service on July 7.</p> <p>Observation in the east pantry area on July 15, 2024, at 9:30 AM, revealed one box of fudge round cookies not dated.</p> <p>Observation in the east pantry area refrigerator on July 15, 2024, at 9:31 AM, revealed one container of thickened cranberry juice open without an open date.</p> <p>Observation of the July 2024, east pantry area refrigerator temperature logs on July 15, 2024, at 9:32 AM, failed to reveal temperatures logged on July 5, 8, and 11 through 14, 2024.</p> <p>Observation in the arcadia pantry area on July 15, 2024, at 9:33 AM, revealed one bin of snacks labeled use by July 13, 2024.</p> <p>Observation in the arcadia pantry area refrigerator on July 15, 2024, at 9:34 AM, revealed nineteen individual juices all not dated.</p> <p>Observation of the arcadia pantry area refrigerator temperature logs from April to July 2024, on July 15, 2024, at 9:35 AM, failed to reveal temperatures logged on April 8, 12, 15, 19 through 22, and 31, 2024; May 14, 15, 19, 28 and 29, 2024; June 1, 2, 7, 17, and 25, 2024; and July 5 through 11, 2024.</p> <p>Interview with the Nursing Home Administrator on July 16, 2024, at 1:09 PM, revealed it is the facility's expectation that food items and kitchen equipment should be stored and utilized in accordance with professional standards.</p> <p>28 Pa. Code 211.6(f) Dietary services</p> <p>28 Pa. Code 201.18(b)(3) Management</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253</p> <p>Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that each resident's medical record includes documentation that indicates the resident or resident's representative was provided education regarding the benefits and potential side effects of the pneumococcal and influenza immunizations for four of five residents reviewed for immunizations (Residents 17, 25, 47, and 107).</p> <p>Findings Include:</p> <p>Review of facility policy, titled IC600 Influenza Immunization Program, revised September 1, 2023, revealed,</p> <p>Obtain consent for influenza vaccination; patient immunization consent is documented in PointClickCare (PCC) [electronic health record] --Patient Informed Consent or Declination; document influenza vaccination refusals. If patient/representative or employee refuses influenza immunization, provide information and counseling regarding the benefit of immunization. If immunization refused, document patient's and/or representative's refusal of immunization and education and counseling given regarding the benefit of immunization in the medical record.</p> <p>Review of facility policy, titled IC 601 Pneumococcal Vaccination, revised November 1, 2023, revealed, Based on the patient's pneumococcal vaccination history, offer (unless the vaccination is medically contraindicated, or the patient has already been vaccinated) the appropriate vaccination following the recommended schedule. Offer the PCV20 vaccine to adults 19-[AGE] years of age with underlying medical conditions. Adults aged greater than or equal to [AGE] years who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown should receive a pneumococcal conjugate vaccine PCV20. Provide the patient/representative education (Vaccine Information Statement-VIS) regarding the benefits and potential side effects of vaccination. Document education, including VIS, in PCC [electronic health record]. Obtain patient/representative consent within the electronic health record. PCV20 may be given at least 5 years after most recent pneumococcal vaccine dose.</p> <p>Review of Resident 17's clinical record revealed diagnoses that included chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure) and bladder cancer.</p> <p>Review of Resident 17's clinical record revealed that Resident 17 refused the both the pneumococcal vaccination and influenza vaccination. Further review of Resident 17's clinical record revealed no evidence that Resident 17 or Resident 17's Representative were educated on the benefits and potential side effects of the vaccinations.</p> <p>Review of Resident 25's clinical record revealed diagnoses that included chronic diastolic heart failure (heart failure that occurs when the heart does not relax properly between beats causing the heart to be unable to pump an adequate amount of blood to the body) and chronic obstructive pulmonary disease (COPD - a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitations).</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident 25's clinical record revealed that the Resident had last received a pneumococcal vaccine (Prevnar 20) on May 26, 2016, and there was no documentation regarding additional pneumococcal vaccinations.</p> <p>Review of Resident 47's clinical record revealed diagnoses that included congestive heart failure (CHF - condition that develops when your heart doesn't pump enough blood for your body's needs) and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).</p> <p>Further review of Resident 47's clinical record revealed that the Resident had requested the pneumococcal vaccination, but was not documented as receiving the vaccination.</p> <p>Review of Resident 107's clinical record revealed diagnoses that included Parkinson's disease (a long-term degenerative disorder of the central nervous system that mainly affects the motor system) and thyroid cancer.</p> <p>Further review of Resident 107's clinical record revealed that the Resident had refused the pneumococcal vaccination. Further review of Resident 107's clinical record revealed no evidence that Resident 107 or Resident 107's Representative were educated on the benefits and potential side effects of the vaccination.</p> <p>During an interview with the Nursing Home Administrator and Director of Nursing (DON) on July 18, 2024, at 12:38 PM, the DON indicated that she had no additional information to provide for the aforementioned concerns with residents' immunizations. She indicated that Resident 47 had consented in May 2023 for the pneumococcal vaccination, but she would have to go back and review all of Resident 47's medication administration records to see if it had been administered or not.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>46253</p> <p>Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide evidence that education was provided to Residents on the risks and benefits of the COVID-19 vaccine for three of five residents reviewed for immunizations (Residents 17, 25, and 107).</p> <p>Findings Include:</p> <p>Review of facility policy, titled IC604 COVID-19 Vaccination, revised February 7, 2024, revealed, Based on the patient's COVID-19 vaccination history, offer the vaccination following the manufacturer's recommended schedule. Obtain consent. In situations where COVID-19 vaccination requires multiple doses, the patient/patient representative/employee/visiting HCP [Healthcare Provider] is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine before requesting consent for administration of any additional doses. If a patient/patient representative refuses vaccination, document declination on the Immunization Record.</p> <p>Review of Resident 17's clinical record revealed diagnoses that included chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure) and bladder cancer.</p> <p>Review of Resident 17's clinical record revealed that Resident 17 refused the COVID-19 vaccination. Further review of Resident 17's clinical record revealed no evidence that Resident 17 or Resident 17's Representative were educated on the benefits and potential side effects of the vaccine.</p> <p>Review of Resident 25's clinical record revealed diagnoses that included chronic diastolic heart failure (heart failure that occurs when the heart does not relax properly between beats, causing the heart to be unable to pump an adequate amount of blood to the body) and chronic obstructive pulmonary disease (COPD-a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitations).</p> <p>Review of Resident 25's clinical record revealed that the Resident last received a COVID-19 booster vaccine on November 16, 2022. Further review of Resident 25's clinical record revealed no evidence that Resident 25 was offered the booster vaccine(s) or that Resident 25 or Resident 25's Representative were educated on the benefits and potential side effects of the vaccine.</p> <p>Review of Resident 107's clinical record revealed diagnoses that included Parkinson's disease (a long-term degenerative disorder of the central nervous system that mainly affects the motor system) and thyroid cancer.</p> <p>Review of Resident 107's clinical record revealed that the Resident last received a COVID-19 vaccine on October 21, 2021. Further review of Resident 107's clinical record revealed no evidence that Resident 107 was offered the booster vaccine(s) or that Resident 107 or Resident 107's Representative were educated on the benefits and potential side effects of the vaccine.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Nursing Home Administrator and Director of Nursing (DON) on July 18, 2024, at 12:38 PM, the DON indicated that she had no additional information to provide for the aforementioned concerns with residents' immunizations.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		