

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Lancaster Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 East King Street Lancaster, PA 17602	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22502</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that assessments accurately reflected the resident's status for three of 35 residents reviewed (Residents 165, 250, and 396).</p> <p>Findings include:</p> <p>Review of Resident 165's progress note of November 1, 2023, revealed resident was found on the floor and reported severe pain to the lower back and right hip area. The physician was notified and ordered the resident be sent to the hospital. Review of additional progress note of November 1, 2023, revealed that a CT scan (computed tomography scan - type of x-ray that creates cross-sectional images) showed a comminuted impacted right acetabular (hip) fracture with right iliac (hip) muscle hematoma (bruise) and right inferior pubic ramus (part of the pelvis) fracture.</p> <p>Review of Resident 165's significant change MDS (Minimum Data Set - periodic assessment of resident needs) of November 10, 2023, section J1700A indicated that the resident did not have a fall any time in the last month prior to admission/entry or reentry and section J1700C indicated that the resident did not have a fracture related to a fall in the 6 months prior to admission/entry or reentry.</p> <p>Interview with the RNAC (registered nurse assessment coordinator) Employee E6 on May 22, 2024, at 9:10 a.m. confirmed that Resident 165's significant change MDS was coded incorrectly.</p> <p>Review of Resident 250's quarterly Minimum Data Set (MDS-periodic assessment of resident needs) dated April 18, 2024 revealed the resident had a fall with a major injury.</p> <p>Review of Resident 250's clinical record revealed the resident had not had a fall with a major injury in the past year.</p> <p>Interview with Licensed Nursing Employee E6 on May 22, 2024 at 9:45 a.m. confirmed Resident 25 was incorrectly coded for a fall with major injury on the quarterly MDS dated [DATE].</p> <p>Review of Resident 396's discharge MDS dated [DATE] revealed the resident was coded as being discharged to an acute care hospital.</p> <p>Review of Resident 396's progress notes revealed a nursing entry dated February 20, 2024 stating, Patient discharged to home.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Licensed Nursing Employee E6 on May 22, 2024 at 9:45 a.m. confirmed Resident 396 was incorrectly coded for a discharge to an acute care hospital on the discharge MDS on February 20, 2024.</p> <p>F641 Accuracy of Assessments</p> <p>Previously cited 7/27/2023</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>Previously cited 7/27/23</p> <p>28 Pa. Code 211.12(c) Nursing services</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p> <p>Previously cited 7/27/23</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>22502</p> <p>Based on review of clinical records and staff interview, it was determined that the facility failed to develop a comprehensive care plan for one of 35 residents reviewed (Resident 73).</p> <p>Findings include:</p> <p>Review of Resident 73's physician's orders included an order dated September 22, 2023, for Eliquis (anticoagulation - medication used to prevent blood clots) 2.5 milligrams one tablet twice a day for paroxysmal atrial fibrillation (type of irregular heartbeat). Review of quarterly MDS (Minimum Data Set - periodic assessment of resident needs) of March 20, 2024, revealed that resident was receiving an anticoagulant.</p> <p>Review of Resident 73's current care plan revealed no care plan or interventions for anticoagulant medication.</p> <p>Interview with the Nursing Home Administrator on May 21, 2024, at 1:30 confirmed that Resident 73 did not have a care plan to address the anticoagulant.</p> <p>483.21 Comprehensive Resident Centered Care Plan</p> <p>Previously cited 7/27/23</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>Previously cited 7/27/23</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p> <p>Previously cited 7/27/23</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>30934</p> <p>Based on clinical record review and staff interview it was determined the facility failed to follow physician orders for three of 40 residents reviewed. (Residents 67, 222, and Resident 223)</p> <p>Findings include:</p> <p>Review of Resident 67's physician's orders included an order dated July 5, 2022, for a 24-hour fluid restriction of 1800 milliliters (ml) with 660 mL from nursing and 1140 mL from dining.</p> <p>Review of Resident 67's clinical record including April 2024 Medication Administration Record (MAR) revealed the resident exceeded the amount of fluids provided by nursing on 29 of 30 occasions.</p> <p>Review of Resident 67's clinical record including May 2024 MAR revealed that the resident exceeded the amount of fluids provided by nursing on 12 of 20 occasions. Further review of the clinical record revealed no documentation of the amount of fluids consumed with meals for May 2024.</p> <p>The above information was presented to the Nursing Home Administrator (NHA) on May 21, 2024, at 1:45 p. m.</p> <p>Review of Resident 222's physician order dated April 6, 2024, revealed an order for a Milk of Magnesia Suspension 400 mg/5ml given 30 cc by mouth every 24 hours as needed for constipation if no bowel movement in three days, give at HS (hours of sleep)</p> <p>Review of Resident 222' s bowel records revealed that the resident did not have recorded bowel movements from May 5, 2024, until May 9, 2024.</p> <p>Review of Resident 222' s May 2024 Medication Administration Record failed to reveal that the resident was administered with as-needed Milk of Magnesia on May 8, 2024.</p> <p>The above information was discussed with the Nursing Home Administrator on May 22, 2024, at 10:00 a.m.</p> <p>Review of Resident 223's physician orders revealed an order dated August 7, 2023 for a 24-hour fluid restriction of 1500 milliliters (ml).</p> <p>Review of Resident 223's clinical record including MAR for March, and April 2024 revealed there was no documentation as to how much fluid the resident had in a 24-hour period and the MAR for May 2024 revealed the resident was coded as having 1500 ml per shift each day which is the total fluid restriction.</p> <p>Interview conducted with Nursing Home Administrator on May 22, 2024 at 10:30 a.m. confirmed there was no documentation of Resident 223's intake for March and April 2023 and the documentation on the MAR for May 2024 was inaccurate prohibiting the facility from ensuring the fluid restriction was being followed as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>483.25 Quality of Care</p> <p>Previously cited 7/23/23</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>Previously cited 11/1/23</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>Previously cited 7/23/23</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p> <p>Previously cited 1/9/24, 7/23/23</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>22502</p> <p>Based on facility policy, clinical record review, and staff interview, it was determined that the facility failed to obtain and monitor weights for two of 35 residents reviewed for nutrition (Residents 259 and 348).</p> <p>Findings include:</p> <p>Review of facility policy Weight Assessment and Intervention revised September 2008 indicated that any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. The dietitian will notify nursing within 48-72 hours after weight is reviewed for needed re-weights.</p> <p>Review of Resident 259's clinical records revealed Resident 259 had a diagnosis of Amyotrophic Lateral Sclerosis (ALS- nervous system disease that weakens muscles and impacts physical function). The resident had a Tracheostomy (An opening surgically created through the neck into the trachea to allow air to fill the lungs) and a Gastrostomy Tube (GT- medical device used to provide nutrition to people who cannot obtain nutrition by mouth).</p> <p>Review of the weight and vitals revealed a weight of 192.5 pounds on April 19, 2024, and a weight of 181.4 pounds on May 13, 2024, an 11.1 pounds (5.77 %) weight loss in less than a month. A review of the same report revealed resident ' s weight was not rechecked until May 21, 2024. (181.3 pounds) eight days after significant weight change was identified.</p> <p>Interview with the Dietitian was conducted on May 22, 2024, who reported that she/he was not notified of the significant weight loss identified on May 13, 2024. The employee learned about the weight loss on May 21, 2024, when the reweight was done. The dietitian confirmed that the resident should have been re-weighed within 24-48 hours when a significant weight change is identified.</p> <p>Review of Resident 348's clinical record revealed a weight of 118.4 pounds on April 4, 2024. Weight was recorded on May 7, 2024 at 105.8 pounds (loss of 12.6 pounds or 10.6%) with no reweight obtained.</p> <p>Further review of Resident 348's clinical record revealed a weight of 93.2 pounds on May 12, 2024 (loss of 12.6 pounds or 11.9% over five days) with no reweigh obtained.</p> <p>Further review of Resident 348's clinical record revealed no evidence that the Registered Dietitian reviewed the record due to the significant weight loss.</p> <p>Interview with the Registered Dietitian, Employee E9, on May 22, 2024, at 9:15 a.m. revealed that reweights should be done within 24-48 hours for a significant weight loss of 5% or more. Employee E9 also confirmed that reweights should have been completed for Resident 348.</p> <p>28 Pa. Code 211.5(f) Clinical Records</p> <p>Previously cited 7/27/23</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>28 Pa. Code 211.10(c) Resident Care Policies</p> <p>Previously cited 7/27/23</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services</p> <p>Previously cited 7/27/23</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>22502</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to provide enteral nutrition (delivery of nutrition by a feeding tube) in accordance with physician's order for four of 11 residents receiving enteral feeding (Residents 72, 244, 259, and 364).</p> <p>Findings include:</p> <p>A review of the facility's policy titled Enteral Nutrition, revised in November 2018, revealed facility will provide adequate nutritional support through enteral nutrition to the residents as ordered.</p> <p>Review of Resident 72's physician's order of October 18, 2023 included an order for enteral feeding Jevity 1.5 via peg tube continuous at a rate of 55 milliliter(mL)/hour for a total volume of 1210 mL/24 hours.</p> <p>Review of Resident 72's April 2024 Medication Administration Record (MAR) revealed that the resident exceeded 1210 mL/24 hours for six of 30 days. Documentation on four of 90 shifts revealed staff were documenting the rate of 55 mL/hour instead of the volume received.</p> <p>Review of the May 2024 MAR revealed that the resident exceeded 1210 mL/24 hours for three of 20 days and two of 60 shifts documented the rate of 55 mL/hour.</p> <p>This information was presented to the NHA on May 21, 2024, at 1:45 p.m.</p> <p>Clinical records review revealed Resident 244 had a diagnosis of Anoxic brain damage (Which occurs when the brain is deprived of oxygen). The resident had a Tracheostomy (An opening surgically created through the neck into the trachea to allow air to fill the lungs), and a Gastrostomy Tube (GT- A medical device used to provide nutrition to people who cannot obtain nutrition by mouth).</p> <p>A review of Resident 244's Physician's order dated January 9, 2024, revealed Enteral Feed Order: Osmolyte 1.5 Cal @ 55 ml/hr. Total volume per hour 1210 ml.</p> <p>A review of the May 2024, Medication Administration Record dated May 1, 2024, until May 22, 2024, revealed that Resident 244 was not provided with a total volume of 1210 ml of Osmolyte on the following days: May 3, 4, 5, 10, 11, 12, 16, 17, 18, and 19 2024. The total GT feeding provided on those days ranged only from 550 ml to 1035 ml which was less than the total feeding volume ordered by the physician.</p> <p>Clinical records review revealed Resident 259 had a diagnosis of Amyotrophic Lateral Sclerosis (ALS- A nervous system disease that weakens muscles and impacts physical function). The resident had a Tracheostomy and a GT.</p> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 259's Physician's order dated April 19, 2024, revealed an Enteral Feed order every shift: Nutren 1.5 via peg tube continuous at rate 45 ml for 22/24 hours, documenting total shift intake.</p> <p>A review of the May 2024 MAR failed to reveal a documented feeding tube total shift intake from May 1, 2024, until May 15, 2024. A review of the same MAR revealed a total intake of 450 ml on May 17, 2024, 765 ml on May 18, 2024, and 765 ml on May 19, 2024, which was less than the 990 ml /22/24 hours total feeding intake ordered by the physician.</p> <p>Clinical records review revealed Resident 364 had a diagnosis of Cerebral Infarction (stroke). The resident had a Tracheostomy and GT.</p> <p>A review of Resident 364's Physician's order dated May 6, 2024, revealed an Enteral Feed order every shift: Jevity 1.5 continuous at 60 ml/hr for 22/24 hours administration (Total 1320 ml).</p> <p>A review of the May 2024 MAR from May 6, 2024, until May 22, 2024, revealed that Resident 365 was not provided with a total volume of 1320 ml of Jevity 1.5 on the following days: May 11, 12, 16, 17, and 20, 2024. The total GT feeding provided on hose days ranges only from 600 ml - 960 ml which was less than the total feeding volume (1320 ml) ordered by the physician.</p> <p>The above was conveyed to the Nursing Home Administrator on May 22, 2024, at 11:00 a.m.</p> <p>The facility failed to ensure residents on tube feeding were provided with adequate and ordered tube feeding.</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>47968</p> <p>Based on clinical record review, it was determined the facility failed to administer as needed pain medications for appropriate pain levels for one of ten residents reviewed for unnecessary medications (Resident 97).</p> <p>Findings include:</p> <p>Review of Resident 97's physician's orders revealed an order dated January 30, 2024, for Oxycodone (narcotic pain reliever) 5 milligrams (mg) every 8 hours as needed for moderate to severe pain.</p> <p>Review of Resident 97's May 2024 Medication Administration Report (MAR) revealed the resident received Oxycodone on May 8, 2024, and May 10, 2024, for pain rated 1 on a scale of 1-10.</p> <p>Review of resident 97's April 2024 MAR revealed the resident received Oxycodone 5mg on April 3, 2024, and April 4, 2024, for pain rated 0, April 19, 2024, for pain rated 1, and April 21, 2024, for pain rate 3 on a scale of 1-10.</p> <p>Review of resident 97's March 2024 MAR revealed the resident received Oxycodone 5mg on March 1, 2024, March 2, 2024, and March 3, 2024, for pain rated 1 on a scale of 1-10.</p> <p>Interview with Director of Nursing (DON) on May 22, 2024, at 12:43 pm., confirmed that Resident 97 should not have received as needed pain medication for a pain rating of 0-3. Interview with DON confirmed moderate to severe pain should be rated 4-6.</p> <p>28 Pa Code 211.5 (f) Clinical records</p> <p>28 Pa code 211.10 (c) Resident care policies</p> <p>28 Pa. 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>37789</p> <p>Based on resident interview and clinical record review, it was determined that the facility failed to ensure one of three residents reviewed for dialysis was free of significant medication errors (Resident 220).</p> <p>Findings include:</p> <p>Interview with Resident 220 on May 20, 2024, at approximately 1:10 p.m. revealed the resident received insulin (medication given to lower blood sugar) but was not receiving it correctly. Further interview with Resident 220 at this time revealed the resident did not receive certain medications on the days the resident attended dialysis.</p> <p>Review of Resident 220's physician's orders revealed an order dated May 2, 2024, for insulin lispro (fast acting insulin), inject per sliding scale:</p> <p>If blood sugar is 0-199 - give 0 units of insulin</p> <p>If blood sugar is 200-250 - give 4 units of insulin</p> <p>If blood sugar is 251-300 - give 6 units of insulin</p> <p>If blood sugar is 301-350 - give 8 units of insulin</p> <p>If blood sugar is 351-400 - give 10 units of insulin; and if blood sugar is greater than 400, give 10 units of insulin and call the physician.</p> <p>The order further read to hold the morning insulin dose on Monday, Wednesdays, and Fridays (the resident's dialysis days.)</p> <p>Review of Resident 220's May 2024 Medication Administration Record revealed the resident received insulin on Monday, Wednesday, and Friday mornings on the following dates:</p> <p>Friday, May 3, 2024, at 6:00 a.m. the resident was given 10 units of insulin for a blood sugar of 377</p> <p>Monday, May 6, 2024, at 6:00 a.m. the resident was given 4 units of insulin for a blood sugar of 208</p> <p>Wednesday, May 8, 2024, at 6:00 a.m. the resident was given 10 units of insulin for a blood sugar of 385</p> <p>Monday, May 13, 2024, at 6:00 a.m. the resident was given 8 units of insulin for a blood sugar of 339</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Friday, May 17, 2024, at 6:00 a.m. the resident was given 4 units of insulin for a blood sugar of 221</p> <p>Monday, May 20, 2024, at 6:00 a.m. the resident was given 8 units of insulin for a blood sugar of 305</p> <p>Further review of Resident 220's physician's orders revealed an order dated May 15, 2024, that the facility May adjust medication times on dialysis days as needed.</p> <p>Further review of Resident 220's physician's orders revealed orders dated May 1, 2024 for Bisacodyl (laxative) 5 milligrams (mg) one time a day at 8:00 a.m., Bumetanide (diuretic) 2mg one time daily at 8:00 a.m., Docusate Sodium (stool softener) 100mg once daily at 8:00 a.m., probiotic one capsule one time daily at 8:00 a.m., umeclidinium-vilanterol (inhaler used to treat wheezing and shortness of breath) one puff daily at 8:00 a.m., calcium acetate 667mg two capsules three times daily, lactulose (used to treat cirrhosis) oral solution 20 grams/30 milliliters give 30 mls three times daily, Sevelamer Carbonate (a medication used to treat an increased level of phosphate in the blood) 800 mg two tablets three times daily, and albuterol sulfate (inhaler that relaxes muscles in the airways and increases air flow to the lungs) two puffs every four hours.</p> <p>Review of Resident 220's May 2024 MAR revealed the resident did not receive the abovementioned medications 8:00 a.m. doses on Mondays, Wednesdays, and Fridays, due to the resident being out of the facility at dialysis. There was no documentation to show the medications were offered when the resident returned from dialysis.</p> <p>Interview with the Nursing Home Administrator on May 22, 2024, at approximately 1:30 p.m. confirmed the above findings.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p>		

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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 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>41765</p> <p>Based on observation, resident, and staff interviews, it was determined that the facility failed to ensure assistive devices for eating were made available for one of the 18 residents reviewed (Resident 189).</p> <p>Findings include:</p> <p>Review of resident 189's diagnosis list includes Diabetes with Mononeuropathy (nerve damage caused by high blood sugar levels), legal blindness, and Brachial plexus disorder (An injury in the network of nerve fibers that innervates the skin and musculature of the upper extremity. It causes a burning sensation, numbness or weakness of the arm, severe pain, and inability to move or feel the affected arm).</p> <p>Review of Resident 189's Quarterly Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) dated May 3, 2024, revealed Resident 189 was cognitively intact. The same MDS revealed resident had one side impairment of the upper extremity.</p> <p>Interview was conducted with Resident 189 on May 21, 2024, at 12:10 p.m. The resident reported that due to limitations on his/her hands/fingers, he was provided with a special kind of spoon and fork, and plate to use during meals but has not been provided to him/her during meals for more than a month now.</p> <p>Observation in the presence of licensed nurse Employee E3 was conducted on May 22, 2024, at 8:40 a.m., and revealed resident's meal was served on a regular plate and was provided with a regular spoon and fork.</p> <p>Review of the resident breakfast meal ticket dated May 22, 2024, revealed adaptive equipment: scoop plate; large, handled fork; left-handed spoon.</p> <p>Interview with Licensed nurse, Employee E3 was conducted on May 22, 2024, at 8:45 a.m., and confirmed Resident 189 uses an adaptive utensil and a scoop plate during mealtime. Employee E3 does not know the reason why Resident was not provided with his/her adaptive spoon and plate.</p> <p>Interview with non licensed, Employee E4 was conducted on May 22, 2024, at 8:48 a.m. Employee E4 reported being the regular nurse aide of Resident 189. Non licensed, Employee E4 reported that she/he was informed that the resident's adaptive utensils and plate comes from the kitchen. Employee E4 reported that the kitchen had not sent the resident's adaptive equipment for eating for almost a month now.</p> <p>Review of the Occupational Therapy notes dated October 24, 2023, revealed Resident will use built-up utensils and scoop plates with supervision during mealtime to increase participation and independence with successful mealtimes for self-feeding.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Rehabilitation Director, Employee E5 was conducted on May 22, 2024, at 11:00 a.m., who confirmed that OT recommended that the resident use an adaptive equipment device for eating on October 24, 2023.</p> <p>The facility failed to ensure Resident 189 was provided with the recommended adaptive equipment device during mealtime.</p> <p>28 Pa. Code: 211.5(f) Clinical records</p> <p>28 Pa. Code: 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41765</p> <p>Based on observations, clinical record reviews, and staff interviews, it was determined the facility failed to ensure Enhanced Barrier Precautions (EBP-infection control prevention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) were in place for residents requiring enhanced barrier precautions for nine of nine residents reviewed (Residents 59, 67, 72, 106, 130, 152, 220, 343, and 364).</p> <p>Findings include:</p> <p>Review of the facility's policy titled Enhanced Barrier Precautions (EBP) dated April 2024, revealed EBP employees targeted gown and glove use during high-contact resident care activities in which there is an opportunity for transfer of MDRO (Multiple Drug Resistant Organisms) to staff hands and clothing. EBP is indicated for residents with the following: Wounds and/or indwelling medical devices regardless of MDRO infections or colonization status; Indwelling medical devices: urinary catheters, feeding tubes, tracheostomies, and ventilators. Appropriate notification/signage is placed at the room entrance indicating the type of precaution and instruction for PPE use.</p> <p>Clinical records review revealed Resident 59 had a Stage 4 Pressure Ulcer (Full-thickness skin and tissue loss) pressure ulcer to the left medial malleolus (inner side of the ankle)</p> <p>Observation conducted of Resident 59's room failed to reveal evidence of EBP signage/communication.</p> <p>Observation on May 21, 2024, at 1:05 p.m., revealed Resident 67 had an indwelling Foley catheter.</p> <p>Observation conducted of Resident 67's room failed to reveal evidence of EBP signage/communication.</p> <p>Observation on May 20, 2024, at 12:05 p.m. revealed Resident 72 had a Gastrostomy Tube</p> <p>Observation conducted of Resident 72's room failed to reveal evidence of EBP signage/communication.</p> <p>Observation conducted on March 19, 2024, at 9:30 a.m., revealed Resident 106 had a Tracheostomy tube (curved tube that is inserted into the opening made in the neck and trachea) and Gastrostomy Tube (GT-medical device used to provide nutrition to people who cannot obtain nutrition by mouth).</p> <p>Observation conducted of Resident 106's room on the first three days of the survey failed to reveal evidence of EBP (Enhanced Barrier Precautions) signage/communication.</p> <p>Observation on May 20, 2024, at 9:30 a.m., revealed Resident 130 had a GT and indwelling Foley catheter (A medical device that helps drain urine from your bladder)</p> <p>Observation conducted of Resident 130's room failed to reveal evidence of EBP signage/communication.</p> <p>Observation conducted on March 19, 2024, at 10:40 a.m., revealed Resident 152 had a Tracheostomy tube and Gastrostomy Tube.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation conducted of Resident 152's room on the first three days of the survey failed to reveal evidence of EBP signage/communication.</p> <p>Clinical records review revealed Resident 220 had a left heel wound on a Negative pressure wound therapy (A therapeutic technique using a suction pump, tubing, and a dressing to remove excess exudates and promote wound healing).</p> <p>Observation conducted of Resident 220's room failed to reveal evidence of EBP signage/communication.</p> <p>Observation conducted on March 19, 2024, at 10:00 a.m., revealed Resident 343 had a Tracheostomy tube and Gastrostomy Tube.</p> <p>Observation conducted of Resident 343's room on the first three days of the survey failed to reveal evidence of EBP signage/communication.</p> <p>Observation conducted on March 19, 2024, at 9:40 a.m., revealed Resident 364 had a Tracheostomy tube and Gastrostomy Tube.</p> <p>Observation conducted of Resident 364's room on the first three days of the survey failed to reveal evidence of EBP signage/communication.</p> <p>Interview was conducted with licensed nurse Employee E3 on May 21, 2024, at 11:30 a.m. Employee E3 was unable to provide information regarding the EBP process/procedures.</p> <p>An interview with the Director of Nursing was conducted on May 22, 204, at 11:00 a.m. The DON confirmed that the EBP process was not fully implemented due to waiting for more supplies.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		