STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395775	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sena Kean Nursing and Rehabilitation Center	17083 Route 6 Smethport, PA 16749

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)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to provide a resident and/or his/her representative with a summary of the baseline care plan for three of five residents reviewed for baseline care plans (Resident R31, R103 and R105). Findings include: Review of facility policy entitled, Care Plans Baseline dated 1/17/24, revealed The resident and/or representative are provided a written summary of the baseline care plan that includes, but is not limited to the following .Goals and objectives, summary of medications, dietary instructions, and treatments. Review of Resident R31's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (condition when your lungs do not have adequate air flow), hypertension (high blood pressure), and heart failure (a condition where the heart cannot supply the body with enough blood). Review of Resident R31's clinical record revealed an assessment dated [DATE], Baseline care plan which revealed a question Were the baseline care plans shared with the resident and/or resident representative? The question revealed the answer no. Further review of Resident R31's clinical record lacked evidence that a summary of the care plan that included goals and objectives, a summary of medications, dietary instructions and treatments was provided to Resident R31 and/or his/her representative. Review of Resident R103's clinical record revealed an admitted [DATE], with diagnoses that included hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones), hypertension, and hyperlipidemia (high cholesterol). Review of Resident R103's clinical record revealed an assessment dated [DATE], Baseline care plan which revealed a question Were the baseline care plans shared with the resident and/or resident representative? The question revealed the answer no. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident R103's clinical record lacked evidence that a summary of the care plan that included goals and objectives, a summary of medications, dietary instructions and treatments was provided to Resident R103 and/or his/her representative. Review of Resident R105's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), hypertension, and dysphagia (difficulty swallowing). Review of Resident R105's clinical record revealed an assessment dated [DATE], Baseline care plan which revealed a question Were the baseline care plans shared with the resident and/or resident representative? The question revealed no answer. Further review of Resident R105's clinical record lacked evidence that a summary of the care plan that included goals and objectives, a summary of medications, dietary instructions and treatments was provided to Resident R105 and/or his/her representative. During an interview on 5/30/24, at 1:57 p.m. the Regional Nurse Consultant confirmed that there was no evidence that Residents R31, R103 and R105 and/or their representatives were provided a summary of the care plan that included goals and objectives, a summary of medications, dietary instructions, and treatments. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41309 Based on review of facility policy and clinical record, observation, and staff interviews, it was determined that the facility failed to ensure medications were consumed for one of seven residents reviewed during medication administration review (Resident R55). Findings include: Review of facility policy entitled Administering Medications dated 1/17/24, revealed Medications are administered in a safe and timely manner . Review of facility education/training entitled Checklist for oral medication administration revealed Remain with the resident until each medication is swallowed. Never leave medication at the resident's bedside. And Review of facilities audit tool entitled Medication Administration Observation Audit, revealed Resident is observed until all meds are ingested. Review of Resident R55's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (condition when your lungs do not have adequate air flow), chronic kidney disease (a disease that affects the kidney's ability to filter waste products and extra fluid from the body), and disorientation (an altered mental state where a person does not know their location, identity, or time). Observation on 5/29/24 at 9:42 a.m. revealed a medication cup filled with multiple unknown medications sitting on the resident's bedside tray table. Resident R55 was sitting in his/her wheelchair in front of his/her bedside table. Resident R55 stated staff doesn't wait for me to take my pills because it takes me a while. He/she also stated, there is a pill on the floor. A small white unknown medication was observed laying on the floor in front of Resident R55's bedside tray table. Further observations revealed the Licensed Practical Nurse (LPN) was down the hallway assisting other residents. During an interview on 5/29/24, at 9:49 a.m. Registered Nurse Employee E1 confirmed that there was a cup filled with unknown medications sitting on Resident R55's bedside table without staff present. He/she also confirmed that medications should never be left at bedside and the nurse administering medications should stay with the resident until the resident ingested the medications. 28 Pa. Code 211.9(a)(1)(c) Pharmacy Services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 41309 Based on review of facility policy, observations, and staff interviews it was determined that the facility failed to appropriately discard outdated medications for one of three medication carts reviewed (West A Hall medication cart). Findings include: Review of facility policy entitled Administering Medications with a policy review date of 1/17/24, indicated The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. Review of Novolog Insulin manufacturer's guidelines revealed after initial use a vial may be kept at temperatures below 30 degrees Celsius (86 degrees Fahrenheit) for up to 28 days, but should not be exposed to excessive heat or sunlight. Observation of drug storage on 5/30/24, at 10:58 a.m. of the [NAME] A Hall medication cart revealed a vial of Novolog Insulin with an open date of 4/10/24, which was beyond the expiration date of 28 days after opening. During an interview at the time of the observation, Licensed Practical Nurse (LPN) Employee E2 confirmed that the Novolog Insulin vial should have been discarded and not remaining in the medication cart for resident use as it was beyond the 28 days after opening. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41309 Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to follow acceptable infection control practices regarding enhanced barrier precautions during observation of care of a gastric tube for one of 25 residents reviewed (Resident R2). Findings include: Review of the facility policy entitled Administering Medications with a policy review date of 1/17/24, revealed that staff follows established infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Review of the facility policy entitled Enhanced Barrier Precautions implemented in April 2024, revealed Standard Precautions continue to apply to the care of all residents, regardless of suspected of confirmed infection or colonization status. Enhanced Barrier Precautions (EBP) employs targeted gown and glove use during high-contact resident care activities in which there is opportunity for transfer of Multi-Drug Resistant Organisms (MDRO) to staff hands and clothing. EBP are indicated for residents with any of the following wherever they reside in the facility: Infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply; or wounds and/or indwelling medical devices, regardless of MDRO infection of colonization status. Indwelling medical devices include, but not limited to central lines or PICC lines, urinary catheters, feeding tubes, tracheostomies and ventilators, and dialysis catheters. Appropriate notification/signage is placed at the room entrance indicating the type of precaution and instructions for Personal Protective Equipment (PPE) use. PPE will be available to staff for donning (put on) prior to entering the resident's room. Doffing (take off) to occur before leaving the residents room Observation of a tube feeding administration for Resident R2 on 5/29/24, at 1:44 p.m. revealed that Licensed Practical Nurse (LPN) Employee E3 washed hands, donned gloves, entered Resident R2's room, and positioned Resident R2 for administration of the enteral tube feeding. LPN Employee E2 proceeded to check placement of Resident R2's enteral feeding tube and administer the enteral feeding. LPN Employee E2 then repositioned the resident in bed for comfort, doffed gloves and washed hands. During an interview with LPN Employee E2 on 5/29/24, at approximately 1:55 p.m. it was confirmed that gloves and a gown should have been worn during administration with an enteral feeding tube due to EBP. Observation of Resident R2's room revealed that there was no signage alerting persons of EBP for infection control and no PPE available outside of the room for use. During an interview on 5/29/24, at approximately 1:58 p.m. the Infection Preventionist confirmed that EBP were not in place and employees should be wearing gloves and gowns when working with enteral feeding tubes. 28 Pa. Code 211.10(c) Resident care policies (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(1)(5) Nursing services