

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395784	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER Church of God Home, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 801 N. Hanover Street 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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>33879</p> <p>Based on clinical record review, observation, policy review, staff interview, and facility document review, the facility failed to protect the resident's right to be free from physical abuse by a staff member for one of three residents reviewed for abuse (Resident 1).</p> <p>Findings include:</p> <p>Review of facility policy, titled Abuse, Neglect and Exploitation, last revised June 23, 2024, revealed the statement, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Review of Resident 1's clinical record revealed diagnoses that included dementia (irreversible, progressive degenerative disease of the brain that results in decreased contact with reality and decreased ability to perform activities of daily living) and hypertensive heart disease (group of heart conditions caused by chronic high blood pressure).</p> <p>Review of facility incident report completed by Employee 2 (Registered Nurse Supervisor) revealed that on November 17, 2024, at 8:00 PM, Employee 4 reported that Employee 1 had struck Resident 1.</p> <p>Review of Employee 4's witness statement said, [Employee 1] asked me to help with a resident to get him cleaned up. I assisted him with helping get [Resident 1] into bed. We attempted to try to clean him up [Resident 1] got combative so [Employee 1] got another [nurse aide] to help. So we all 3 tried to clean resident up & [Resident 1] hit [Employee 1] in his face. Tried to tell [Employee 1] walk away & [reapproach] later but [Employee 1] then hit resident twice. First time on his right side I believe & then punched [Resident 1] in his face.</p> <p>Review of Employee 5's witness statement, dated November 17, 2024, revealed Employee 5 witnessed Employee 1 strike Resident 1 stating, ,as I let go [of Resident's 1 hands] Resident 1 [struck] [Employee 1]. [Employee 1] did respond and [struck] the resident .</p> <p>Review of Resident 1's clinical record revealed Resident 1 was transported to the hospital for evaluation and returned with no identified concerns.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of Resident 1 on November 18, 2024, revealed Resident 1 had light bruising to the outer aspect of the right eye.</p> <p>During a staff interview on November 19, 2024, at approximately 3:10 PM, Nursing Home Administrator confirmed it was the facility's expectation that residents are free of abuse.</p> <p>28 Pa code 201.18(b)(1)(2)(3) Management</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>33879</p> <p>Based on clinical record review, staff interviews, and facility document review, it was determined that the facility failed to provide care and services in accordance with professional standards of practice for one of 18 residents reviewed for skin issues (Resident 18).</p> <p>Findings include:</p> <p>Review of Resident 18's clinical record revealed diagnoses that included dementia (irreversible, progressive degenerative brain disease that results in decreased contact with reality and decreased ability to perform activities of daily living) and hypertension (elevated/high blood pressure).</p> <p>Further, review of Resident 18's clinical record revealed that on October 15, 2024, a physician communication form stated, Resident [18's] family [complaint of] rash like areas on [right] arm. The physician responded with an order for hydrocortisone cream 1% twice a day as needed.</p> <p>At 4:00 PM, a interdisciplinary note was entered which stated, POA [Power of Attorney] (son) made aware of new order for hydrocortisone cream [due to] [bilateral upper extremity] rash. POA voiced concern for possible need bath soap change. Resident may benefit from dove soap.</p> <p>Review of Resident 18's clinical record revealed no assessment of the rash to Resident 18's right arm which provided possible characteristics of the rash (size, presentation, area).</p> <p>During interview on November 19, 2024, at approximately 1:15 PM, Director of Nursing confirmed that there was no assessment of Resident 18's rash.</p> <p>During a staff interview on November 19, 2024, at approximately 3:10 PM, Nursing Home Administrator revealed it was the facility's expectation that Resident 18's rash would have been assessed when identified.</p> <p>28 Pa code 211.12(d)(1)(3)(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>33879</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on clinical record review, review of Centers for Disease Control and Prevention guidance, facility documentation review, and staff interviews, it was determined that the facility failed to implement infection control practices to prevent or limit the spread of infectious disease for 13 of 17 residents reviewed for skin conditions (Residents 2, 4, 5, 7, 8, 9, 10, 11, 13, 14, 15, 16, and 17).</p> <p>Findings include:</p> <p>Review of the Centers for Disease Control and Prevention (CDC) guidance, titled Public Health Strategies for Scabies Outbreaks in Institutional Settings, dated December 18, 2023, revealed the guidance stated:</p> <p>Prevention: Early detection, treatment, and implementation of appropriate isolation and infection control practices are essential in preventing scabies outbreaks. Institutions should maintain a high index of suspicion that undiagnosed skin rashes and conditions may be scabies, even if characteristic signs or symptoms of scabies are absent (e.g. no itching). New patients/residents and employees should be screened carefully and evaluated for any skin conditions that could be compatible with scabies. The onset of scabies in a staff person who has had scabies before can be an early warning sign of undetected scabies in a patient/resident. When there is concern for scabies in a person, skin scrapings should be obtained and examined carefully by a person who is trained and experienced in identifying scabies mites. Appropriate isolation and infection control practices (e.g., gloves, gowns, avoidance of direct skin-to-skin contact, etc.) should be used when providing hands-on care to patients/residents who might have scabies. Epidemiologic and clinical information about patients/residents with confirmed and suspected scabies should be collected and used for systematic review in order to facilitate early identification of and response to potential outbreaks.</p> <p>Surveillance: Establish surveillance. Have an active program for early detection of infested patients/residents and staff. Maintain a high index of suspicion that scabies may be the cause of undiagnosed skin rash; evaluate and confirm suspected cases by obtaining skin scrapings .</p> <p>Diagnostic Services: Ensure that adequate diagnostic services are available. Consult with an experienced dermatologist for assistance in differentiating between skin rashes and scabies.</p> <p>During a staff interview on November 19, 2024, at approximately 12:30 PM, Director of Nursing (DON) revealed the facility did not have a specific policy or procedure for scabies and that the facility would follow the CDC guidance for a scabies outbreak.</p> <p>Review of available facility documentation revealed that the facility had identified an increase in skin rashes in the facility population since approximately December 2023.</p> <p>Review of the documentation revealed 23 residents were monitored for skin rashes. Of those 23 residents that were included in the facility monitoring, 16 were still living in the facility with continued rashes at the time of the onsite survey on November 18, 2024, and confirmed by the DON via an electronic communication on November 19, 2024, at 2:14 PM.</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>Review of the documentation for the 16 residents still residing in the facility, revealed rashes were identified on the following dates:</p> <p>Resident 2, July 21, 2023</p> <p>Resident 3, May 7, 2024</p> <p>Resident 4, October 11, 2024</p> <p>Resident 5, September 4, 2024</p> <p>Resident 6, December 24, 2023</p> <p>Resident 7, May 26, 2024</p> <p>Resident 8, August 14, 2024</p> <p>Resident 9, October 24, 2024</p> <p>Resident 10, November 2, 2024</p> <p>Resident 11, October 21, 2024</p> <p>Resident 13, September 28, 2024</p> <p>Resident 14, March 26, 2024</p> <p>Resident 15, August 5, 2024</p> <p>Resident 16, March 23, 2024</p> <p>Resident 17, June 26, 2024</p> <p>Based on review of clinical records, Resident 18 was identified as having complaints of a rash that was communicated to the physician, but no assessment or tracking of the skin condition was implemented.</p> <p>Resident 3 had developed a rash on May 7, 2024. Review of the facility documentation revealed that between May 7, 2024, and November 7, 2024, Resident 3 had been treated multiple times for the rash and had multiple medications, oral and topical (on skin) ordered to treat the rash and itching. However, Resident 3's rash persisted and results of a skin scrape (scraping of the skin observed under a microscope in an attempt to confirm scabies infection) conducted by consultant dermatologist on November 7, 2024, confirmed the presence of scabies (contagious skin condition caused by parasites that borrow into the skin) eggs and mites.</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>During an interview with DON on November 18, 2024, at approximately 1:20 PM, DON confirmed that the only residents who was on contact precautions for scabies was Resident 3 and Resident 6, who shared the room with Resident 3. Resident 6 was being monitored for a rash that was first identified December 24, 2023.</p> <p>During the interview, DON confirmed that no skin scrapes had been conducted for any other residents that presented with rashes and, at that time, the facility did not have the means to collect skin scrapes of rashes. DON also revealed that no skin scrapes had been conducted on residents with rashes prior to Resident 3's skin scrape on November 7, 2024.</p> <p>As of November 18, 2024, the facility failed to implement isolation and infection control practices for Residents 2, 4, 5, 7, 8, 9, 10, 11, 13, 14, 15, 16, and 17 for undiagnosed rashes after a confirmed case of scabies in the facility. Further, at that time the facility had not secured testing via skin scrapes for residents who present with a rash.</p> <p>During a staff interview on November 19, 2024, at approximately 3:10 PM, Nursing Home Administrator revealed it was the facility's expectation that the facility follow the CDC's guidelines after scabies have been identified in the building.</p> <p>28 Pa code 201.18(b)(1)(3) Management</p> <p>28 Pa code 211.12(d)(1)(3)(5) Nursing services</p>		