

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395785	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Stonebridge Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 102 Chandra Drive Duncannon, PA 17020	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, to promote healing of a pressure ulcer for one of two residents reviewed for pressure ulcers (Resident 6).</p> <p>Findings include:</p> <p>Review of facility policy, titled Clean Dressing Change Policy last revised, March 10, 2024, read, in part, Wounds will be dressed using a clean technique which avoids direct contamination of material and supplies. Apply new dressings as ordered. Document procedure and update findings.</p> <p>Review of Resident 6's clinical record revealed diagnoses that included pressure ulcer of right heel (wound that occurs when the skin and tissue are damaged by prolonged pressure) and osteoarthritis (a type of arthritis that affects the joints in your body).</p> <p>Review of Resident 6's physician orders revealed the following pressure wound order: Treatment as follows: Cleanse right heel with soap & water, pat dry. Apply betadine then calcium alginate to base of wound, secure with ABD (abdominal pad), three times a day, with a start date of March 26, 2025.</p> <p>Review of Resident 6's MAR (Medication Administration Record - documentation for treatments/medication administered or monitored), revealed his treatments were documented as not administered during night shift on March 31, 2025; and April 1 and 8, 2025.</p> <p>During an interview with the Director of Nursing (DON) on April 10, 2025, at 2:11 PM, revealed she spoke with Employee 2 (Licensed Practical Nurse) who stated she did not administer the treatments because it was noted on the evening shift on March 31, 2025, that the wound treatment order needs clarified. However, no one reached out to clarify the order throughout the week, so she just continued to not administer. The DON further revealed she would expect wound treatments to be administered as ordered and clarified timely if needed.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to provide routine drugs and biologicals to its residents and provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for three of seven residents reviewed (Residents 1, 2, and 3).</p> <p>Findings include:</p> <p>Review of facility policy, titled Delivery and Receipt of Routine Deliveries subsection Long-Term Care Facilities Receiving Products and Services from Pharmacy last revised August 1, 2024, read, in part, Receipt of Medications and Supplies: A facility nurse should inspect the package(s) for any damage or errors and notify pharmacy as soon as possible but within twenty-four hours of any damage or other discrepancies. If any item ordered by the facility is not received in the delivery, facility staff should check for a pharmacy slip explaining the reason a medication or item was not delivered. Facility should contact pharmacy if facility requires an explanation for the missing items or medications and document any delivery discrepancies.</p> <p>Review of Resident 1's clinical record revealed he was admitted to the facility on [DATE], with diagnoses that included orbital eye cellulitis (a serious bacterial infection that affects the fat and muscle tissue within the eye socket) and other lower back pain.</p> <p>Review of Resident 1's clinical record revealed he had physician orders for cefepime (antibiotic medication) via intravenous infusion (IV infusion- medication and fluid that is administered directly into a vein), three times daily, with a start date of February 12, 2025, and to be completed on February 26, 2025.</p> <p>Review of Resident 1's MAR (Medication Administration Record - documentation for treatments/medication administered or monitored) revealed it was noted he failed to receive four administrations of his IV antibiotic between when he was admitted to the facility and the next day, with corresponding notes that the medication was unavailable.</p> <p>Review of Resident 1's nursing progress notes revealed a note written by Employee 6 (Registered Nurse) on February 13, 2025, at 1:57 PM, that stated, IV medications arrived from pharmacy at this time, provider updated on missed doses from this morning. New order to extend IV antibiotic for additional doses not received this morning. It was not noted that the provider was made aware of the missed doses on February 12, 2025.</p> <p>Further review of Resident 1's physician orders revealed he had an order for MS Contin (morphine pain medication) tablet extended release, 15 mg, twice a day, and Morphine concentrate solution, three times a day, with a start date of February 12, 2025.</p> <p>Further review of Resident 1's MAR revealed the MS Contin was not administered on February 12, 2025, and three doses of the morphine concentrate solution were not administered between his admission and his AM dose on February 13, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 1's nursing progress notes revealed a note written by Employee 6 on February 13, 2025, at 8:07 PM, that states she spoke to the pharmacy who stated MS Contin is unavailable on backorder and that the doctor was notified. The doctor ordered to discontinue the MS Contin and start Oxycodone, but that the Resident declined the Oxycodone, and stated he would just take the liquid morphine and hydrocodone (pain medication) that were available starting on February 13, 2025.</p> <p>Review of Resident 2's clinical record revealed he was admitted to the facility on [DATE], with diagnoses that included malignant neoplasm of prostate (malignant tumor involving the prostate gland) and generalized weakness.</p> <p>Review of Resident 2's clinical record revealed he had a physician order for Casodex (an anti-androgen, it works in the body by preventing the actions of androgens or male hormones), with a start date of March 16, 2025.</p> <p>Review of Resident 2's MAR revealed it was noted he failed to receive two administrations of the Casodex with corresponding notes that the medication was unavailable on March 16 and 17, 2025.</p> <p>Review of Resident 3's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included epilepsy (a neurological disorder that causes seizures or unusual sensations and behaviors) and multiple sclerosis (an autoimmune disease that affects the central nervous system).</p> <p>Review of Resident 3's clinical record revealed the following physician orders:</p> <p>Lacosamide (a medication used to treat seizures) 200 mg, twice a day, take with 50 mg tab twice a day, with a start date of April 7, 2025.</p> <p>Lacosamide 50 mg, twice a day, take with 200 mg tab twice a day, duration 30 days, with a start date of April 7, 2025.</p> <p>Review of Resident 3's MAR revealed it was noted she failed to receive two administrations of both orders of the Lacosamide, from when she was admitted to the facility and the next day, with corresponding notes that the medication was unavailable.</p> <p>Review of Resident 3's nursing progress notes revealed an admission note written by Employee 1 (Registered Nurse) on April 7, 2025, at 7:27 PM, that read, in part, Resident arrived to facility at 2:24 PM. All medications arrived STAT (without delay or immediately) to facility except Lacosamide.</p> <p>Further review of Resident 3's nursing progress notes revealed a note written by Employee 6 on April 8, 2025, at 9:04 PM, that stated, Spoke with provider and made aware of not receiving 50 mg dose of Lacosamide from pharmacy. Lacosamide 200 mg dose arrived from pharmacy this evening. Per provider, resident to receive Lacosamide 200 mg dose this evening. Spoke with pharmacy, 50 mg dose will be delivered on late pharmacy run.</p> <p>Interview with Employee 1 on April 9, 2025, at 11:43 AM, revealed they sometimes have issues with delayed medication deliveries or order discrepancies, but that it is the responsibility of the nursing staff to address these issues with the pharmacy and/or doctor when they are discovered.</p> <p>(continued on next page)</p>		

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<p>F 0755</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 the Director of Nursing (DON) on April 9, 2025, at 2:15 PM, the surveyor revealed the concern with the delay in the medication deliveries and administrations for Residents 1, 2, and 3. In addition, the surveyor requested information as to the delay in contact with the pharmacy and/or doctor when the medications were initially noted to be unavailable, why the medications were unavailable for extended periods, if any delivery discrepancies were documented for review, and to provide information related to the medication delivery schedule from the pharmacy.</p> <p>Review of select facility documentation provided from the pharmacy, revealed scheduled medication delivery for new orders and admissions are as follows: Pharmacy departure on Monday through Friday at 11:30 AM and 12:30 AM overnight; and Saturday, Sunday, and Holidays at 1:00 PM.</p> <p>During a follow-up interview with the NHA and DON on April 10, 2025, at 2:03 PM, the DON revealed that in the case of the IV antibiotic medication, they had the medication onsite, but in a different dose, so they should have reached out to the doctor on the day he was admitted to see if he could utilize that until his proper dose arrived from pharmacy. The NHA and DON revealed they were unable to provide information related to the delay in medications delivered to the facility, as there are various delivery times from pharmacy. They further revealed they would be meeting with the pharmacist to evaluate their in-house medication stock; and revealed their expectation that medications would be available timely to meet the needs of each resident, and the doctor would be notified of discrepancies, delays, or medications unavailable from pharmacy.</p> <p>28 Pa. Code 211.9(d)(2) Pharmacy services</p> <p>28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing services</p>		