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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395815 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/21/2025 |
| NAME OF PROVIDER OR SUPPLIER St Martha Center for Rehabilitation & Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 470 Manor Ave Downingtown, PA 19335 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <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>47968</p> <p>Based on a review of facility policy, observations, clinical records and staff interviews, it was determined that the facility failed to follow physician orders for two of 22 residents reviewed (Resident 86 and 164).</p> <p>Finding include:</p> <p>A review of the facility's policy regarding Enteral Nutrition, dated March 2020, revealed adequate nutritional support through enteral feeding will be provided to residents as ordered.</p> <p>A review of Resident 86's clinical records revealed medical diagnoses that include Dysphagia following other Cerebrovascular Disease (swallowing disorder that occurs after a stroke or other neurological disease), Muscle Wasting and Atrophy (loss of muscle mass), and Severe Protein-Calorie Malnutrition (inadequate protein or calories in diet).</p> <p>Review of Resident 86's clinical records revealed a physician order dated January 9, 2025, for Jevity 1.5 at 40ml/ per hour x20 hours via Kangaroo pump (pump that delivers nutrition through a tube inserted in the stomach or intestine that's programmed with desired feed rate and volume), total volume 800ml per day or until infused. Down at 11am, up at 3pm. This provides 1200 kcal, 51g protein and 608ml free water every shift for Peg-Tube.</p> <p>Observations of Resident 86's Kangaroo pump on February 18, 2025, at 9:30 a.m., revealed the pump was already disconnected from the resident and turned off.</p> <p>Observations of Resident 86's Kangaroo pump on February 19, 2025, at 9:40 a.m., revealed the pump was already disconnected from the resident and turned off.</p> <p>A review of Resident 86's February Medication Administration Record (MAR) revealed the resident received the following amounts of Jevity daily:</p> <p>February 1-2, 300ml evening, 0ml night, 160ml day for a total of 460ml</p> <p>February 2-3 320ml evening, 230ml night, 160ml morning for a total of 480 ml</p> <p>February 3-4 320ml evening, 230ml night, 160ml morning for a total of 780ml</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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>February 4-5 250ml evening, 0ml night, 160ml morning for a total of 420 ml</p> <p>February 5-6 320ml evening, 40ml night, 160ml morning for a total of 520ml</p> <p>February 6-7 300ml evening, 240ml night, 160ml morning for a total of 700ml</p> <p>February 7-8 240ml evening, 230ml night, 240ml day for a total of 710ml</p> <p>February 8-9 240ml evening, 240ml night, 0ml day for a total of 480ml</p> <p>February 9-10 300ml evening, 300ml night, 160ml day for a total of 760ml</p> <p>February 10-11 0ml evening, 240ml night, 160ml day for a total of 400ml</p> <p>February 11-12 300ml evening, 240ml night, 160ml day for a total of 700ml</p> <p>February 12-13 300ml evening, 240ml night 160ml day for a total of 700ml</p> <p>February 13-14 300ml evening, 230ml night, 0ml day for a total of 530ml</p> <p>February 14-15 0ml evening, 230ml night, 160ml day for a total of 390ml</p> <p>February 15-16 320ml evening, 230ml night, 160ml day for a total of 710ml</p> <p>February 16-17 150ml evening, 90ml night, 0ml day for a total of 240ml</p> <p>February 17-18 280ml evening, 230ml night, 160ml day for a total of 510ml</p> <p>February 18-19 200ml evening, 245ml night, 160ml day for a total of 605ml</p> <p>February 19-20m 300ml evening, 240ml night 160ml day for a total of 700ml</p> <p>Review of Resident 86's February 2025 MAR failed to reveal any day that the resident received the prescribed amount of tube feed.</p> <p>Interview conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on February 20, 2025, at 12:07 p.m., when the above information was presented, the ADON stated that the Kangaroo pump shuts down when the total 800ml is infused. The ADON stated the pump clears itself when it is shut off and there was no way to see a 24-hour look-back of total amounts dispensed for the pump.</p> <p>The DON confirmed that the amounts documented on the resident's MAR should equal the total amount prescribed in the physician orders. The DON confirmed the amounts on the resident's February MAR did not match the physician orders.</p> <p>A review of Resident 164's diagnosis list includes Type II Diabetes Mellitus (A chronic disease where the body does not use insulin properly or does not produce enough of it, causing high blood sugar levels).</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>A review of the physician's order dated February 1, 2025, revealed an order for Insulin Aspart Injection Solution 100 ml/unit (fast-acting insulin) Inject 12 units subcutaneously (Injection is given in the fatty tissues, just under the skin) every six hours-injection to be given at 12:00 a.m. midnight, 6:00 a.m., 12 noon, and 6:00 p.m.</p> <p>A review of Resident 164's February 2025, Medication Administration Record revealed that from February 1, 2025, until February 18, 2025, Insulin Aspart was not administered to the resident seven times on the following dates: February 4, 2025, at 6:00 p.m.; February 5, 2025, at noon; February 7, 2025, at midnight; February 11, 2025, at 6:00 p.m.; February 14, 2025, at 6:00 p.m.; February 15, 2025, at 12:00 a.m., and 6:00 a.m.</p> <p>MAR review revealed Aspart Insulin 12 units were not administered on February 4, at 6:00 p.m., and February 5, at 12 noon. The MAR was coded with 9 which indicated BS (blood sugar) within limit coverage.</p> <p>MAR review revealed Aspart Insulin 12 units were not administered on February 7, 11, 14, and 15, at the times listed above. The MAR was coded with a 5 which indicated Hold/see nurses' notes</p> <p>A review of the progress notes dated February 7, 2025, at 3:23 a.m., revealed BS was 97 mg/dl.</p> <p>A review of the progress notes dated February 11, 2025, at 6:25 p.m., revealed Aspart Insulin 12 units was held for BS of 127 mg/dl.</p> <p>A review of the progress notes dated February 14, 2025, at 5:41 p.m., revealed Aspart Insulin 12 units was held for BS of 97 mg/dl.</p> <p>A review of the progress notes dated February 15, 2025, at 12:18 a.m., revealed BS was 102 mg/dl.</p> <p>A review of the progress notes dated February 15, 2025, at 5:20 a.m., revealed BS was 110 mg/dl.</p> <p>Clinical records review failed to reveal that the physician was notified that Aspart Insulin 12 units was not administered to Resident 164 on the above dates/time.</p> <p>The above was confirmed with the Director of Nursing on February 21, 2025, at 1:00 p.m.</p> <p>The facility failed to ensure Resident 164's physician order for Insulin was followed by holding insulin despite there being no parameters for the administration of insulin.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p> <p>Previously cited 1/12/24</p> |

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| <p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>41765</p> <p>Based on clinical records review and staff interview, it was determined that the facility failed to ensure appropriate indications and non-pharmacological interventions were provided before administering as-needed anti-anxiety medications for two of five residents reviewed (Residents 3 and 22).</p> <p>Findings include:</p> <p>A review of Resident 3's physician's order dated May 24, 2024, revealed an order for Ativan (anti-anxiety medication) gel 1mg/ml applied to the base of the neck topically two times a day for Anxiety. On September 24, 2024, an order for Ativan gel 1mg/ml applied to the neck every eight hours as needed for anxiety was ordered aside from the routine Ativan gel.</p> <p>A review of the November 2024, Medication Administration Record revealed that from November 1, 2024, until November 30, 2024, as needed Ativan gel was administered to Resident 3 seven times with no appropriate indication and was administered five times without attempting a non-pharmacological intervention.</p> <p>A review of Resident 22's physician's order dated January 16, 2025, revealed an order for Clonazepam 0.5 mg (anti-anxiety medication) every 12 hours as needed for Anxiety.</p> <p>A review of the January 2025, MAR revealed that from January 17, 2025, until January 31, 2025, Resident 22 was administered with as-needed Clonazepam nine times without appropriate indication. The MAR also revealed that non-pharmacological interventions were not attempted before administering the as-needed Clonazepam nine times.</p> <p>The above was confirmed with the Director of Nursing on February 21, 2025, at 12:07 p.m.</p> <p>The facility failed to ensure Resident 3 and 22 were administered with as-needed anti-anxiety medication with appropriate indication and attempted non-pharmacological interventions prior to the administration of the as needed psycotropic medication.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p> <p>Previously cited 1/12/24</p> | | |