STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395818	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Lafayette Hill	801 Ridge Pike Lafayette Hill, PA 19444

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43277 Based on review of facility documentation, review of clinical record, and staff interviews, it was determined that the facility failed to provide adequate supervision and assistance resulting in a fall for one of two residents reviewed for falls (Resident R16). Findings Include: Review of Resident R16's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated February 7, 2024, revealed the resident was cognitively intact had diagnoses of hemiplegia or hemiparesis and muscle weakness. Continued review of Resident R16's MDS Section GG - Functional Abilities and Goals revealed the resident had impairment on one side of the upper and lower extremity. Review of Resident R16's comprehensive care plan dated February 7, 2024, revealed the resident was at risks for falls related to Cerebrovascular Accident (CVA - an obstruction or bleed from a blood vessel of the brain causing brain damage) with left-sided weakness, ataxia (a condition that affects muscle coordination and can cause clumsy movements and balance problems)/spastic movements and history of falls. Continued review of Resident R16's comprehensive care plan dated February 7, 2024, revealed the resident had a seatbelt on the wheelchair due to poor trunk control/spasticity. Review of Resident R16's physical therapy progress report for dates of service 2/27/2024 through 3/8/2024 revealed during static standing, the resident demonstrated increased lean to left and required minimal assist to maintain an upright posture. Review of Resident R16's physical therapy treatment encounter notes dated 3/18/2024 and 3/20/2024 revealed balance in standing was identified as poor and safety awareness was identified as impaired. Review of facility documentation submitted to the state survey agency on March 25, 2024, revealed Resident R16 sustained a fall on March 24, 2024. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility incident report dated March 24, 2024, revealed on March 24, 2024, Licensed Nurse, Employee E9, noticed Resident R16's seatbelt was not fastened. Licensed Nurse, Employee E9, then asked Resident R16 to stand up so the licensed nurse could adjust the seatbelt. Resident R16 subsequently stood up, holding onto a walking, and fell to the left. Review of statement dated March 25, 2024, from Licensed Nurse, Employee E9, revealed the licensed nurse noticed Resident R16's seatbelt was not on. Licensed Nurse, Employee E9, could not retrieve the set belt while Resident R16 was in the chair. Licensed Nurse, Employee E9, placed a stand-up walker in front of Resident R16 so the resident could stand up while Licensed Nurse, Employee E9, attempted to retrieve the seatbelt on the wheelchair. Per the statement by Licensed Nurse, Employee E9, once Resident R16 was steady with the stand-up walker and Resident R16's friend who was in the room offered to stand by the resident, Licensed Nurse attempted to retrieve the seatbelt, but it was found to be stuck. The friend went to assist Licensed Nurse, Employee E9, leaving Resident R16 unassisted, when Resident R16 subsequently fell sideways without warning, landing on his left side and hitting his head on the wall. Interview on September 19, 2024, at 12:06 p.m. with Director of Therapy, Employee E10, confirmed Resident R16 was not safe to stand up, holding onto the stand-up walker, unassisted. Director of Therapy, Employee E10, indicated that Resident R16 was impulsive, not steady, and required hands on contact guard assistance. Interview on September 19, 2024, at 12:50 p.m. with Director of Nursing, Employee E2, revealed having a friend of Resident R16 to assist was not appropriate as the friend was not trained by the facility and it was not deemed safe. 28 Pa. Code 211.10 (c) Resident care policies 28 Pa. Code 211.12 (d)(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. 48347 Based on observation, facility documentation, facility policy review and staff interview, it was determined that the facility failed to store and label drug according to professional standards of practice on one of one medication room. (Second Floor) Findings include: Review of facility policy provided, titled Medication Storage from the Department of Health and Human Services, Centers for Medicare, and Medicaid Services, revealed medications and biologicals that are stored in medication rooms, carts, boxes, and refrigerators will be maintained within secured locks and accessible only to designated staff. A sufficient detailed record of receipt and disposition of controlled medications are to be maintained to enable an accurate reconciliation. Review of the medication Lorazepam's insert revealed risks of use with opioids including Lorazapam may result in profound sedation, respiratory depression, coma, and death. Lorazepam has a potential for abuse and may lead to dependence. Observation of the only medication room shared within three nursing units on the facility second floor on September 19, 2024, at 11:29 a.m. accompanied with Licensed nurse, Employee E3 revealed the medication/ vaccine refrigerator was observed with a large sign on the door stating that the medication refrigerator must be always locked. The door was checked to verify it was locked and the door was found to be unlocked. Employee E3 confirmed the observation. Continued observation of the medication refrigerator found containing vaccines, insulin, and other medications that require a low tempeture. Examined contents of the refrigerator revealed a total of four boxes of lorazepam (the brand name Ativan is a prescription medication control drug use the management of anxiety disorders insomnia panic attacks and alcohol withdrawal) one box was noted to be in an open container labeled with a resident name a dosage information. One box was noted to be enclosed in a see-through locked box with no resident name or prescription on the label. Two boxes of the unopened Lorazepam with no name on the label or prescription were noted to be set on the shelf with no closed, locked, or secured disposition for anyone in the medication room to access. Interview with Licensed nurse, Employee E3 reveal the one box with the resident name identified on the label is recorded in the narcotic book on the medication cart. The other boxes with no name or prescription on the label are pharmacy extra. According to Employee E3, the boxes of any narcotics in the medication refrigerator are supposed to be in a locked box. The key can only be obtained from the pyxis (machine that provides secure medication storage along with electronic tracking of the use of narcotics and other controlled medications) by a supervisor. The act of removing the medication from the pyxis is witnessed and documented. Interview with Director of Nursing, Employee E2 on September 19, 2024, at 11:55 a.m. confirmed that the boxes of lorazepam should be in the locked box. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.12 (d) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347 Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to ensure proper infection control practices were followed during medication pass between two resident and by implementing proper use of personal protective equipment (PPE) when practicing enhanced barrier precautions during care for three of 12 residents reviewed. (Resident R32, R42 and R5) Findings include: Review of facility policy titled Infection Prevention and Control revealed that in accordance with state and federal guidance the facility has established and will maintain, and infection prevention and control program designed to provide a safe sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections this policy defines our overarching infection prevention and control program. Further review of this policy revealed hand hygiene a general term that applies to washing hands with water or thoroughly applying an alcohol-based hand sanitizer. Exercising general infection control practices Hand hygiene is the single most important means of reducing risk of transmitting microorganisms from one person to another or from 1 site to another on the same resident. Review of facility policy titled Hand Hygiene revealed that the facility has established and will maintain an infection prevention and control program designed to provide a safe sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection. Further view of this policy reveals when to wash your hands before eating before direct contact with a resident skin and then serving invasive devices The alcohol hand sanitizer may be used routinely for hand hygiene unless hands are visibly soiled then soap and water hand washing is required. According to Centers for Disease Control and Prevention (CDC- United States federal agency under the department of Health and Human Services, its main goal is to protect public health and safety through the control and prevention of disease) website https://www.cdc.gov/cleanhands/hcp/clinical-safety / describes the hand washing must be done immediately before touching a patient, before performing an aseptic task such as placing an indwelling device or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces and immediately after glove removal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Infection Transmission Prevention and Intervention revealed that enhanced barrier precautions infection control intervention to prevent the spread of MDRO(multi drug resistant organisms, which is a microorganism that is resistant to multiple class of antimicrobials, such as antibiotics and antifungals. MDROs are bacteria that can cause serious infections). Enhanced barrier precautions pertain to residents that have a history of MDRO infection, are now colonized residents that have an indwelling medical device such as inner dwelling urinary catheter, a feeding tube, a central line, residents that have a wound or wounds must apply a gown and gloves during high contact activities such as dressing, bathing, transferring, changing linens, providing incontinence care, device care, and wound care. Entrance to a residence's room identified by CDC enhanced barrier precautions should display a sign on the door. Observation of Licensed nurse, Employee E8 on September 18, 2024 at 9:10 a.m. revealed this employee was completing the task of taking a residents vitas in the hallway. After completing the vitals and recording the data in the computer,Llicensed nurse, Employee E8 prepared medication for Resident R32 . Resident R32 was waiting in the hallway for Employee E8 to administer the medications, Employee E8 handed her a medication cup containing pills, she dropped one, he picked it up off of her shirt and handed it to her, then handed her a cup of water. Licensed nurseEmployee E8 then prepared medication for Resident R42 who was also waiting in the hallway . He prepared the medication and placed the pills in a medication cup and handed the cup to Resident R42. Employee E8 then handed Resident R42 a cup of water. Employee E8 was observed not washing hands or hand sanitzer proper between residents. Interview with Licensed nurse, Employee E8 revealed that the sanitizer was located on the wall , Employee E8 then walked over to the the hand sanitizer on the wall and pointed it to surveyor. The surveyor asked why he did not use the sanitizer between resident employee stated if you say so he then denied the observation to the Director of Nursing, Employee E2. Observation of sign on the resident R5's door revealed that the resident is under enhanced barrier precautions and everyone must clean hands before entering and leaving the room. Providers and staff must wear gloves and gown for the following activities: dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. All devise care of central line, urinary catheter, feeding tube, tracheostomy, and all wound care requiring dressing. Review of Resident R5's Minimum Data Set (MDS-a federal mandated process for clinical assessments of all residents) admission assessment dated [DATE], revealed that Resident R5 was admitted into the facility on [DATE] with a diagnosis of urinary tract infection and fractured hip. Resident R5 had a urinary catheter and required use assisted devices of a wheel chair and walker. Resident R5 required maximal assists for Activities Daily Living's such as oral hygiene, toileting,bathing,dressing, and personal hygiene. Observation of Resident R5 on September 17, 2024 at 10:05 a.m. revealed that this resident was receiving morning care and dressed by nursing assistant, Employee E6 and Employee E5. Both employees, nursing assistant Employee E6 and nursing assistan, Employee E5 were observed with gloves, neither employee donned a gown. Interview with Employee E5 revealed that the resident is not currently on any precaution, the sign was left on the door mistakenly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Infection Preventionist, Employee E4 , during the above observation,confirmed the Resident R5 is under enhanced barrier precaution and gowns must be worn when providing care. Employee E4 confirmed that Employee E6 and Employee E5 were not applying the proper infection prevention practice. 28 Pa. Code 211.12 (d)(1) Nursing services 28 pa code 211.12 (d)(5) Nursing services