

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395824	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/23/2024
NAME OF PROVIDER OR SUPPLIER  Emmanuel Center for Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  600 School House Road Danville, PA 17821	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</b></p> <p>Based on a review of clinical records, resident council meeting minutes, and resident and staff interviews, it was determined the facility failed to provide care in a manner that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by two residents out of the 20 residents sampled (Residents 19 and 21) and experiences reported by five out of the six residents during a resident group interview (Residents 5, 12, 19, 21, and 42).</p> <p>Findings include:</p> <p>A review of Resident Council meeting minutes dated October 21, 2024, revealed residents in attendance raised concerns about long wait times for staff to respond and provide care after ringing their call bells for assistance. The residents in attendance indicated that staff will initially respond to their call bell, turn off the bell, but do not provide care.</p> <p>A review of Resident Council meeting minutes dated November 22, 2024, revealed residents in attendance raised concerns that staff are turning off the call bell lights but not providing care. Residents in attendance indicating that a staff will initially respond and turn off her call bell light but not perform care until after some time passes.</p> <p>A review of Resident Council meeting minutes dated December 17, 2024, revealed residents in attendance raised concerns regarding not having enough staff to assist residents back to their rooms after meals in the dining room.</p> <p>A clinical record review revealed Resident 19 was admitted to the facility on [DATE], with diagnoses that included disease of the spinal cord, unspecified (damage to the spinal cord that is not otherwise specified).</p> <p>A review of a significant change in status Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 2, 2024, revealed that Resident 19 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on December 21, 2024, at 10:25 AM, Resident 19 indicated she often waits 20 minutes for staff to provide her care after she rings her call bell for assistance. She explained that it has been an ongoing problem that staff initially respond, turn off her call bell light, but do not provide her care for 15 or 20 minutes later. She indicated that she has had to adapt to going to the bathroom when staff are available. She explained she had to learn how to s&amp;*t on command because staff may not be available the next time she rings her bell for assistance. Resident 19 indicated when the facility uses agency staff, it extends the wait times for care, because they do not know the residents as well as the in-house staff. She explained that the facility uses agency staff a few times a week.</p> <p>A clinical record review revealed Resident 21 was admitted to the facility on [DATE], with diagnoses that included hydrocephalus (a condition where cerebrospinal fluid builds up in the brain, increasing pressure on brain tissue).</p> <p>A review of an admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 22, 2024, revealed that Resident 21 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</p> <p>During an interview on December 21, 2024, at 11:35 AM, Resident 21 indicated she often waits a while for care. She explained the wait time for staff to provide care has been up to an hour when staffing is low. She explained staffing is low a few times a week. Resident 21 indicated she is happy her ability to care for herself is increasing, because now she doesn't have to wait as much for staff assistance to take her to the bathroom.</p> <p>During a group interview with alert and oriented residents on December 22, 2024, at 10:00 AM, five out of the six residents (Residents 5, 12, 19, 21, and 42) interviewed indicated they have concerns about the long wait times to receive care from staff after ringing their call bells for assistance. Residents 5, 12, 19, 21, and 42 explained they are frustrated and upset because they rely on staff for care.</p> <p>During the group interview, Resident 12 indicated she waits an hour to an hour and a half for care. She explained the long wait times for care are the worst when agency staff are working at the facility.</p> <p>During the group interview, Resident 5 indicated she waits 20 to 30 minutes for care. She explained often, staff will turn off her call bell light without providing her care. Resident 5 indicated she is embarrassed because she sometimes soils herself while waiting for staff to assist her to the bathroom.</p> <p>During the group interview, Resident 4 indicated he sometimes waits an hour to an hour and a half for staff to provide care after he rings his call bell for assistance. He explained he is frustrated because he often waits and waits for staff.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the group interview, Resident 42 indicated she waits a long time for staff to escort her from the dining room. She explained there is not enough staff to escort residents back to their rooms after meals. Resident 42 indicated she is often pushed to the hallway and waits 20 or 30 minutes in the hallway for staff to be available to assist her back to her room after meals.</p> <p>During an interview on December 22, 2024, at approximately 1:00 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) verified all residents at the facility should be treated with dignity and respect and provided care in a manner that promotes each resident's quality of life. The NHA and DON were unable to explain why residents are reporting untimely staff responses to residents' requests for assistance and care.</p> <p>28 Pa. Code 201.18 (e)(1) Management.</p> <p>28 Pa. Code 201.29 (a) Resident rights.</p> <p>28 Pa. Code 211.12(c)(d)(4) Nursing services.</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>48277</p> <p>Based on review of clinical records and select facility policy, observations and staff interview, it was determined the facility failed to provide meal service in an environment that maintains each resident's dignity for three residents out of 6 sampled (Residents 26, 44, and 58), and failed to provide medication in a manner that respected the resident's dignity for one resident out of 20 sampled (Resident 31).</p> <p>Findings include:</p> <p>Review of the facility policy titled Dignity- Quality of Life last reviewed by the facility in August 2024, revealed the facility promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect.</p> <p>A review of Resident 26's clinical record revealed she was severely cognitively impaired.</p> <p>And required total assistance from staff to be fed her meals.</p> <p>An observation conducted on December 21, 2024, at 12:05 PM of the 100-nursing unit dining room revealed Resident 26 and Resident 44 seated together at a table. At 12:06 PM Resident 26's lunch meal was delivered and placed on the table in front of her. Staff continued to serve other residents their lunch meals in the 100-unit dining room while Resident 26's lunch meal remained in front of her.</p> <p>At 12:16 PM, Resident 44 was served her lunch meal and began eating, while Resident 26's meal remained untouched due to the lack of staff assistance. A staff member did not begin assisting Resident 26 until 12:20 PM, 14 minutes after her meal was delivered.</p> <p>Additional observation of the 100-nursing unit dining room revealed Resident 58 seated at a table with Resident 57. Resident 57 was served her lunch meal at 12:09 PM and began eating immediately. Resident 58 did not receive her lunch meal until 12:22 PM, 13 minutes later, by which time her tablemate had finished eating.</p> <p>A review of Resident 31's clinical record revealed diagnosis which included generalized osteoarthritis, neuralgia (severe, sharp pain that follows the path of the nerve), and neuritis (inflammation of the nerves).</p> <p>Review of Resident 31's physician orders revealed an order dated July 6, 2024, for Bio freeze External gel 4% (gel used to treat minor aches and pains of the muscle/joints), apply to left foot topically four times a day for pain.</p> <p>(continued on next page)</p>

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On December 21, 2024, at 12:28 PM, Employee 3 (a licensed practical nurse) was observed in the 100-nursing unit dining room, during the lunch meal, repositioning Resident 31's wheelchair, removing her left sock, and applying Bio freeze gel to her left foot. This procedure was conducted in the dining room's common area, in the presence of multiple residents, and during the lunch meal service. This action did not afford Resident 31 privacy or dignity, as the procedure was performed in a public space and inappropriately timed during the meal service.</p> <p>During an interview conducted on December 23, 2024, at 10:45 AM the Nursing Home Administrator and Director of Nursing confirmed that the lunch meal service on the 100-nursing unit was not conducted in a manner that promotes each residents' dignity. They also confirmed that it is the facility's expectation for employees to provide Bio freeze applications in residents' rooms to ensure privacy and dignity.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services</p>

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48276</p> <p>Based on a review of clinical records and staff interview it was determined the facility failed to provide residents or their representatives with written information of the facility's bed hold policy upon transfer to the hospital of one resident out of 20 residents sampled (Resident 10).</p> <p>Findings include:</p> <p>A review of Resident 10's clinical record revealed the resident was transferred to the hospital on December 5, 2024, and returned to the facility on [DATE].</p> <p>There was no documented evidence the facility provided Resident 10 and/or her representative written information about the facility's bed-hold policy (an agreement for the facility to hold a bed for an agreed-upon rate during a hospitalization ) at the time of transfer.</p> <p>Interview with the Nursing Home Administrator (NHA) on December 22, 2024, at approximately 1:00 PM confirmed that the facility was unable to provide documented evidence indicating Resident 10 and/or Resident 10's representative was provided the facility's bed hold policy upon hospital transfer.</p> <p>28 Pa Code 201.18 (e)(1) Management.</p> <p>28 Pa Code 201.29 (b) Resident rights.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</b></p> <p>Based on a review of clinical records, observation, and resident and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of practice by failing to thoroughly assess, obtain physician orders, and develop and implement a person-centered comprehensive care plan in accordance with standards of practice, for two residents out of 20 sampled residents (Residents 41 and 43).</p> <p>Findings include:</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care:</p> <p>Assessments</p> <p>Clinical problems</p> <p>Communications with other health care professionals regarding the patient</p> <p>Communication with and education of the patient, family, and the patient's designated support person.</p> <p>A cardiac loop recorder monitors the heart's electrical activity and transmits data to physicians for managing conditions like arrhythmias (irregular heart rhythms).</p> <p>Proper documentation and care planning ensure:</p> <p>Monitoring for Symptoms: Identifying signs of device-related complications or abnormal heart rhythms.</p> <p>Timely Intervention: Staff can promptly address concerns or escalate issues to a physician.</p> <p>Comprehensive Care: Avoiding complications, such as infections at the implant site, through routine assessments and interventions.</p> <p>A review of the clinical record revealed that Resident 41 was admitted to the facility on [DATE], with diagnoses that included hypertension (elevated blood pressure) and cerebral infarction (stroke).</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 - Some</p>	<p>During an observation of Resident 41's room on December 21, 2024, at 11:33 AM, a remote electronic transmitter device (a device that records and sends data from a device implanted in a person directly to the physician's office using Wi-Fi or cellular data) was located on the resident's bedside table. During an interview with Resident 41, a cognitively intact resident, he confirmed he had some type of small device that resembles a paperclip implanted in his chest. He reported that he had the device for over two years, before he was admitted to the facility.</p> <p>A review of Resident 41's hospital records obtained by the facility on December 23, 2024, at the request of the surveyor, revealed the resident underwent a loop recorder implant (a heart recording device, implanted in the body under the chest skin, that records heart rate and rhythm continuously. It monitors the heart's electrical activity and records and sends the data to the cardiologist via a remote transmitter device) placement on January 26, 2022.</p> <p>A review of Resident 41's Admission assessment dated [DATE], failed to document the presence of the loop recorder implant.</p> <p>Review of Resident 41's admission assessment, physician orders, and care plan revealed no documentation of the loop recorder or any corresponding care requirements, despite the potential for heart rhythm complications.</p> <p>Review of Resident 41's plan of care, in effect at the time of the survey ending December 23, 2024, identified that Resident 41 had a potential for complications with heart/circulation due to atrial fibrillation (an irregular heartbeat that reduces the heart's ability to pump blood through the body, which means you do not get enough oxygen) or other dysrhythmia's and hypertension. The facility failed to identify the presence of, or the care for, the resident's implanted loop recorder on the resident's current plan of care.</p> <p>A review of the clinical record revealed that Resident 43 was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (stroke), and the presence of a cardiac and vascular implant and graft.</p> <p>During an observation of Resident 43's room on December 21, 2024, at 1:15 PM, a remote electronic transmitter device was located on the resident's bedside table.</p> <p>A review of Resident 43's hospital records obtained by the facility on December 23, 2024, at the request of the surveyor, revealed the resident underwent a loop recorder implant placement on August 16, 2024.</p> <p>Review of a nurses note dated August 16, 2024, at 3:15 PM revealed the Electrophysiology report was received from the procedure. The resident had a loop recorder implantation completed.</p> <p>A review of Resident 43's IDT (Interdisciplinary Team) care conference summary dated August 26, 2024, failed to identify, and document the presence of the newly implanted loop recorder.</p> <p>A review of the weekly skin check tool dated September 2, 2024, (first skin check performed since resident's procedure on August 16, 2024) indicated that there were no new skin issues noted.</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 - Some</p>	<p>Review of Resident 43's physician orders failed to identify the presence of, or care for, the residents loop recorder implant.</p> <p>Review of Resident 43's plan of care, in effect at the time of the survey ending December 23, 2024, identified that Resident 43 had a potential for complications with heart/circulation due to carotid stenosis, hypertension, and peripheral vascular disease. The facility failed to identify the presence of, or the care for, the resident's implanted loop recorder on the resident's current plan of care.</p> <p>The facility was unable to provide documented evidence that the loop recorder implant site was assessed after the implant procedure on August 16, 2024.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on December 23, 2024, at approximately 11:00 AM confirmed the facility's failure to assess and document the presence of the loop recorders, obtain appropriate physician orders, and include the devices in the residents' care plans. This failure placed Residents 41 and 43 at risk for undetected complications and inadequate care.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.</p> <p>28 Pa. Code 211.5(f) Medical records.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48276</p> <p>Based on a review of clinical records, select facility policy, and staff interview, it was determined the facility failed to provide appropriate treatment and services to restore normal bladder function for one out of 20 residents sampled (Resident 21).</p> <p>Findings include:</p> <p>A review of facility policy titled Bowel and Bladder Management, last reviewed by the facility on August 8, 2024, revealed it is the facility's policy to ensure that each resident with bowel or bladder incontinence receives appropriate treatment and services to achieve or maintain as much normal elimination function as possible. The policy indicates residents deemed appropriate will have an individualized toilet schedule or bladder training program. Residents' comprehensive, individualized, person-centered care plan will be updated or revised to include the resident's bowel and bladder needs, goals, and personal preferences.</p> <p>A clinical record review revealed Resident 21 was admitted to the facility on [DATE], with diagnoses that included hydrocephalus (a condition where cerebrospinal fluid builds up in the brain, increasing pressure on brain tissue).</p> <p>A review of an admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 22, 2024, revealed that Resident 21 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</p> <p>The admission MDS assessment dated [DATE], Section GG0170F Mobility, indicated Resident 19 requires substantial and maximal assistance for transferring to the toilet.</p> <p>The admission MDS assessment dated [DATE], Section H0200A Urinary Toileting Program indicated a trial of toileting (e.g., scheduled toileting, prompted voiding, or bladder training) has not been attempted on admissions, entry, or reentry or since urinary incontinence was noted in the facility.</p> <p>A care plan identifying Resident 21 had the potential for complications with bowel and bladder related to current medical and physical status. The care plan goal indicated Resident 21 will be clean and dry with incontinence cares provided as needed through December 3, 2024. Interventions in place are incontinence care with incontinence episodes, medications and creams as ordered, and observation of changes in color, consistency, frequency, odor, discomfort, distention, fever, or confusion.</p> <p>A review of urinary incontinence tracking from dated November 24, 2024, through December 23, 2024, revealed Resident 21 was incontinent of urine on 76 occasions.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on December 23, 2024, at approximately 10:00 AM, the Director of Nursing (DON) was unable to provide documented evidence the facility determined if Resident 21 was appropriate for an individualized toilet schedule or bladder training program. The DON confirmed the facility did not implement a bladder training or individualized toileting schedule to attempt to restore normal bladder functioning for Resident 19. The DON confirmed it is the facility's responsibility to ensure residents are provided appropriate treatment and services to restore normal bladder function.</p> <p>28 Pa. Code 211.10(c) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</b></p> <p>Based on review of clinical records and select facility policy, observation, and staff interview it was determined the facility failed to consistently provide respiratory care and supplemental oxygen, as ordered by the physician for one resident out of 20 sampled. (Resident 2) Additionally, the facility failed to store respiratory equipment in a sanitary manner for one resident out of three sampled receiving oxygen therapy (Resident 41).</p> <p>Findings included:</p> <p>A review of the facility policy titled Oxygen Therapy last reviewed by the facility in August 2024, revealed the E-tanks (oxygen cylinders which contain oxygen under pressure) are used to allow residents to be mobile in the facility and participate in therapy, activities, and meals. The licensed nursing staff will monitor oxygen delivery systems hourly. E-tanks will be changed when they are approximately 1/4 full (at the top of the red areas on the gauge). Tanks and concentrators are checked hourly and initialed on the checklist when in use.</p> <p>During an initial facility tour on December 21, 2024, at 11:33 AM, oxygen tubing attached to the oxygen concentrator (bedside machine that concentrates ambient air to supply an oxygen-rich gas stream), in Resident 41's room was observed lying on the floor. This tubing, including the nasal cannula (flexible plastic tubing with small prongs inserted into the nostrils to deliver supplemental oxygen), was not in use but was not stored in a sanitary manner and was observed lying directly on the floor.</p> <p>Interview with Employee 3 (licensed practical nurse) on December 21, 2024, at 11:40 AM confirmed the oxygen tubing and nasal cannula were improperly stored on the floor.</p> <p>A review of Resident 2's clinical record revealed the resident was admitted on [DATE], with diagnoses to include respiratory failure with hypoxia (not enough oxygen passes from the lungs to the blood, making it difficult to breath), and congestive heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). A physician order dated February 19, 2024, specified oxygen at 3 liters/min via nasal cannula continuously for congestive heart failure.</p> <p>A quarterly MDS (minimum data set- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 5, 2024, indicated the resident was severely cognitively impaired with a BIMS score of 4 (brief interview for mental status, a tool to assess the resident's attention, orientation, and ability to register and recall new information, a score of 0-7 represents severe cognitive impairment). The resident required extensive assistance from staff for activities of daily living and bed mobility.</p> <p>An observation conducted on December 21, 2024, at 12:40 PM revealed that Resident 2 was seated in his wheelchair in the 100-nursing unit dining room. The oxygen tank, located on the back of the wheelchair, was observed to be empty. This observation was confirmed by Employee 3.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Director of Nursing (DON) on December 23, 2024, at approximately 10:45 AM revealed the facility was unable to provide documented evidence that oxygen tanks and concentrators were monitored hourly and recorded as required by the facility's policy. The DON confirmed that Resident 41's oxygen tubing was not stored in a sanitary manner and that the facility failed to provide oxygen therapy as prescribed for Resident 2.</p> <p>28 Pa. Code 211.12 (d)(1)(5) Nursing services</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48276</p> <p>Based on a review of clinical records and staff interviews, it was determined the facility failed to ensure a resident's drug regimen was free of unnecessary antibiotic drugs for one out of 20 residents sampled (Resident 19).</p> <p>Findings included:</p> <p>A clinical record review revealed Resident 19 was admitted to the facility on [DATE], with diagnoses that included disease of the spinal cord, unspecified (damage to the spinal cord that is not otherwise specified).</p> <p>Further clinical record review revealed Resident 19 had physician orders for a Foley catheter, 16 French, with a 30 ml balloon (a type of indwelling urinary catheter, rubber tube inserted into bladder to drain urine) related to neuromuscular dysfunction of the bladder.</p> <p>A clinical record review revealed no documented evidence the resident had experienced any symptoms of a urinary tract infection, such as fever, chills, mental changes/confusion, fatigue, nausea/vomiting, pressure in the lower part of the pelvis, or an increase in urination from October 1, 2024, through October 2, 2024.</p> <p>A urine culture laboratory report dated October 2, 2024, revealed Resident 19's urine tested positive for Escherichia coli (ESBL-extended-spectrum beta-lactamase, which is an enzyme produced by some bacteria that makes them resistant to many antibiotics) quantities between 10,000 and 100,000 colonies/ml.</p> <p>A physician progress note dated October 3, 2024, revealed Resident 19 is feeling tired, experiencing pain under her rib cage, and experiencing nausea. The note indicated the resident does not have fever, chills, or changes in gastrointestinal function. Furthermore, the note indicated laboratory work was completed yesterday and the resident's urine is positive for bacteria. The note indicated Resident 19 is probable for a urinary tract infection and has previously responded well to ceftriaxone 1 gm IM (intra muscular-injection into muscle) daily.</p> <p>A review of a medication administration record dated October 2024 revealed Resident 19 received two doses of ceftriaxone (an antibiotic medication) sodium injection solution reconstituted 1 gm once, on October 3, 2024, and a second dose on October 4, 2024. The medication was discontinued on October 4, 2024.</p> <p>The urine culture laboratory report dated October 2, 2024, revealed the Escherichia coli organism identified in Resident 19's urine is resistant to ceftriaxone antibiotic medication.</p> <p>A McGeer Criteria for Infection Surveillance checklist (a set of standardized guidelines used to define and identify healthcare-associated infections in long-term care facilities, particularly in elderly populations) dated October 4, 2024, revealed Resident 19 did not meet criteria for the use of antibiotic medication.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on December 23, 2024, at approximately 9:45 AM, Employee 2, Infection Preventionist (IP), indicated Resident 19 did not meet criteria to receive antibiotic medication for a urinary tract infection on October 3, 2024. Employee 2, IP, confirmed that Resident 19 did not have a fever, leukocytosis, acute mental status change, or acute functional decline.</p> <p>During an interview on December 23, 2024, at approximately 10:30 AM, the Director of Nursing (DON) confirmed it is the facility's responsibility to ensure that residents' drug regimens are free of unnecessary antibiotic drugs. The DON confirmed Resident 19 received two doses of ceftriaxone (an antibiotic medication) sodium injection solution reconstituted 1 gm once on October 3, 2024, and a second dose on October 4, 2024. The DON was not able to provide documented evidence for the clinical rationale indicating the need for Resident 19 to receive a ceftriaxone sodium injection.</p> <p>28 Pa. Code 211.2 (d)(3) Medical director.</p> <p>28 Pa. Code 211.9 (k) Pharmacy services.</p> <p>28 Pa. Code 211.12 (d)(3) Nursing services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43944</p> <p>Based on observation and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the dietary department and in the 100-Hall and 200-Hall medication room refrigerators.</p> <p>Findings include:</p> <p>Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food).</p> <p>A review of the facility policy entitled Sanitation and Infection Control provided by the facility on December 23, 2024, indicated that all foods are labeled, dated, stored, and securely covered, and use-by dates are monitored and followed.</p> <p>During the initial tour of the dietary department conducted with the facility's weekend day-shift dietary supervisor on December 21, 2024, at 9:30 AM, revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness:</p> <p>Upon entry to the dietary department/kitchen area two garbage cans with lids were full of trash and had red splatter on their exteriors. These cans were located near the tray line area where resident meal trays were being prepared for lunch.</p> <p>Another garbage can, soiled with visible trash inside, was located underneath a stainless-steel sink/workstation and was missing a lid.</p> <p>Near the tray line, clean pitcher lids were stored next to dirty cleaning rags.</p> <p>Two black bins containing bowls with visible debris and food particles were observed on the food preparation sink area, directly across from the tray line.</p> <p>Two boxes of uncovered Danish pastries were stored next to a bottle of cleaning solution and a staff member's personal drink.</p> <p>Several dome lids covers, and clear plastic covers were scattered beneath the sink, and some were uncovered.</p> <p>The lid of the bulk sugar container had visible debris and a yellowish substance adhered to its surface.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The lid of the bulk flour container also had visible debris on its surface.</p> <p>The tubing attached to the filter of the ice machine had a heavy accumulation of dust.</p> <p>The blue plastic ice scoop was cracked, with sharp edges and missing pieces, posing a contamination and safety hazard.</p> <p>Observations of the cook's area revealed the ventilation hood over the cooking equipment had a heavy accumulation of greasy residue combined with dust particles adhered to the pipes and grates.</p> <p>The bulletin board displaying laminated department postings was splattered with dried, crusty substances.</p> <p>Shelving used to store facility manuals and binders was splattered with visible debris.</p> <p>Observations of the cold food prep area revealed on the bottom shelf of a wire rack, a case of bananas was stored less than six inches off the floor, violating proper food storage guidelines.</p> <p>Upon entering the dry food storage room, observed the lid of a gray garbage can had visible food splatter adhered to its surface.</p> <p>Observations inside of the dry food storage room revealed several boxes and bags of pasta were open and not securely sealed or stored in containers to prevent contamination.</p> <p>The dietary day-shift supervisor confirmed these findings and acknowledged that the dietary department must be maintained in a sanitary manner to prevent foodborne illness.</p> <p>Observations of the 100-Hall medication room on December 23, 2024, at 8:51 AM, revealed there were four 4-ounce strawberry nutritional shakes, nine 4-ounce chocolate nutritional shakes, and eight 6-ounce apple cranberry juice drinks were not labeled with a thaw date or use-by date. According to manufacturer instructions, once thawed, these products must be used within 14 days.</p> <p>Additionally, in the presence of Employee 4 an LPN observed that on the 200-Hall Medication Room that there four 6-ounce orange juice drinks and three 6-ounce apple cranberry juice drinks were also found without thaw dates or use-by dates.</p> <p>An interview with Employee 4 on December 23, 2024, at 9:00 AM, confirmed all supplements should be labeled and dated as per manufactures recommendations.</p> <p>Further interview with the Nursing Home Administrator (NHA) on December 22, 2024, at 1:00 PM, confirmed the facility's dietary department is expected to meet sanitary standards to prevent the risk of contamination and foodborne illness.</p> <p>and all nutritional supplements must be properly labeled and stored in accordance with manufacturer instructions.</p> <p>28 Pa. Code 201.18 (e) (2.1) Management</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>28 Pa. Code 211.6 (f) Dietary Services</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43944</p> <p>Based on the review of clinical records and staff interviews it was determined the facility failed to demonstrate coordination of services in the development of the comprehensive plan of care between the facility and a Hospice agency for two residents out of three sampled residents receiving hospice care (Resident 34 and 47).</p> <p>Findings include:</p> <p>Review of Resident 34's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included end stage dementia (very severe cognitive decline and affects individuals by declines in mobility, increased incontinence, increased infection, trouble swallowing/eating, and severe confusion with increased anxiety) with need for hospice care/services (care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure with goals to enable patients to be comfortable and free of pain) and dysphagia (difficulty swallowing).</p> <p>A review of Resident 34's comprehensive person-centered plan of care indicated the resident had signs and symptoms of overall declining conditions and medical diagnosis of end stage dementia with disease process progression and need for hospice care with a goal for the resident to remain comfortable with physical, psychosocial, spiritual, so that life is neither hastened nor prolonged but follows residents process of concluding life. Planned interventions included hospice services, observe for factors that may affect resident's comfort and responses to interventions, observe for end of life needs and review with MD, representative, family for optimizing care, discontinue weights, and allow resident to refuse medications.</p> <p>A review of the clinical record revealed that Resident 34 passed away at the facility on December 22, 2024, at 6:00 PM.</p> <p>Resident 34's comprehensive person-centered plan of care (POC) failed to reflect coordination of services between the facility and the Hospice agency in meeting the resident's daily care needs and specific needs related to care and services provided for the resident's terminal diagnosis.</p> <p>An interview with the Nursing Home Administrator (NHA) on December 22, 2024, at 10:30 AM, confirmed the facility failed to ensure that Resident 34's comprehensive person-centered POC was coordinated and integrated with hospice services.</p> <p>A review of Resident 47's clinical record revealed he was admitted to the facility on [DATE], with diagnoses that included end stage Parkinson's disease (includes severe motor symptoms and cognitive issues like dementia and may have severe posture issues that require a wheelchair, and may be bedridden, increased risk of injuries, and infections) with need for hospice care/service to maintain comfort.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 47's comprehensive person-centered plan of care indicated the resident had signs and symptoms of an overall declining condition and medical diagnosis of end stage Parkinson's disease with disease process progression and need for hospice care with a goal for the resident to remain comfortable with physical, psychosocial, spiritual, so that life is neither hastened nor prolonged but follows residents process of concluding life. Planned interventions included hospice services, observe for factors that may affect resident's comfort and responses to interventions, observe for end of life needs and review with MD, representative, family for optimizing care, discontinue weights, and resident may refuse medications.</p> <p>Through survey ending December 23, 2024, Resident 47's comprehensive person-centered POC failed to demonstrate coordination of services and integration between the facility/interdisciplinary team and Hospice agency.</p> <p>An interview with the Nursing Home Administrator (NHA) on December 23, 2024, at 10:33 AM, confirmed that the facility failed to ensure that Resident 47's comprehensive person-centered POC was coordinated and integrated with hospice services.</p> <p>28 Pa. Code 201.21(c) Use of outside resources</p> <p>28 Pa. Code 211.12 (d)(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 - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41581</p> <p>Based on observation and staff interview it was determined the facility failed to ensure that staff followed proper infection control techniques while passing medications to one of three residents (Residents 38) on the 200 Hall nursing unit.</p> <p>Findings included:</p> <p>An observation on December 22, 2024 at 9:13 AM revealed Employee 1 LPN (licensed practical nurse) was administering morning medications to Resident 38 on the 200 Hall nursing unit. Employee 1 was opened a bottle of calcium tablets and the employee used her bare hand without performing hand hygiene to block the pills from coming out of the bottle, touching the pills, and then picked up the the calcium pill with her ungloved hand and without performing hand hygiene or donning gloves, placed it in Resident 38's medication cup. Further observation revealed the employee knocked over the medication cup where two pills had spilled out on to the medication cart. The employee did not dispose of those pills but picked them up off the medication cart, with ungloved hand and without performing hand hygiene or donning gloves, and placed them back into the medication cup. The employee proceeded to administer the medications to Resident 38. The employee failed to wash her hands after administering the medications.</p> <p>Interview with the Director of Nursing on December 22, 2024, at approximately 11:00 AM confirmed that Employee 1 failed to follow proper infection control measures prior to the administration of these medications.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>