

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395825	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Watsontown Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 245 East Eighth Street Watsontown, PA 17777	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839</p> <p>Based on observation, closed clinical record review, review of facility documents, and staff interview, it was determined that the facility failed to provide the services necessary to prevent accidents resulting in multiple sustained fractures for one of five residents reviewed resulting in actual harm (Resident CR1).</p> <p>Findings include:</p> <p>Closed clinical record review for Resident CR1 revealed a nursing note dated [DATE], at 9:09 PM noting the resident was being turned by a nurse aide and rolled off the bed onto the floor. It was noted the resident had a left dorsal head bump and complaints of severe left hip pain.</p> <p>A follow up nursing note for Resident CR1 dated [DATE], at 9:23 PM indicated the physician had provided a verbal order to send the resident to the emergency room due to the severe left hip pain.</p> <p>Nursing documentation dated [DATE], at 11:34 PM summarized the incident that occurred prior to being transferred to the hospital. The writer noted they heard a loud thump outside of Resident CR1's room and entered the room to find Resident CR1 on the floor between the resident's bed and the first bed in the room. It was noted a hematoma (bruise) was observed on the back of the resident's head on the left side, and the resident had complaints of hip pain. A nurse aide in the room was questioned as to how the incident occurred and what side the resident landed on. The nurse aide in the room replied with, I don't know. The nurse aide was halfway between the resident's bed and bathroom when the writer entered. The writer indicated that based on experience, the resident is unable to roll independently and will continue to roll if she is rolled by the nurse aide and let go. The writer noted the resident left the facility at 9:35 PM to go to the emergency room .</p> <p>A review of Resident CR1's documents from the emergency room visit revealed the resident received several tests in the emergency room dated [DATE], to include x-rays of her bilateral hips, chest, and left shoulder as well as CT scans of her cervical spine, head/brain, chest/abdomen, and pelvis. Review of the resident's emergency department provider summary of the visit revealed the resident was diagnosed with a scalp hematoma (bruise), right hip fracture, multiple left-sided rib fractures, and a left scapular (shoulder blade) fracture. It was noted the residents responsible party declined surgery for the resident's hip fracture.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395825	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Watsontown Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 245 East Eighth Street Watsontown, PA 17777	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note dated [DATE], at 5:55 AM for Resident CR1 indicated the resident returned to the facility from the emergency department at 5:00 AM and staff were not able to complete a full skin assessment due to the resident being in too much pain. Nursing staff administered Morphine (an opioid medication used to treat severe pain).</p> <p>Continued review of Resident CR1's nursing notes after her return to the facility revealed multiple entries of the resident being in pain and requiring increased doses of Morphine. A referral for hospice services to assist with pain management was noted on [DATE], at 8:01 AM.</p> <p>Nursing documentation dated [DATE], at 11:39 AM noted Resident CR1 had a significant decline, noting the resident was unable to eat breakfast, intermittently crying out in pain, presenting cognitive decline, and unable to swallow pills safely. The resident's pain regimen was changed, and the resident was placed on hospice care as of [DATE], at 12:31 PM.</p> <p>Resident CR1 continued to have noted decline, and expired at the facility on [DATE], at 10:23 AM.</p> <p>Closed record review for Resident CR1 revealed the resident was listed in care tasks as requiring maximum assistance of two and a bed rail to the left side for bed mobility since [DATE], and at the time of the incident noted above.</p> <p>A review of Resident CR1's plan of care for ADL deficits (activities of daily living) initiated [DATE], identified an intervention added to the care plan dated [DATE], that the resident required maximum assistance and a bedrail to the left side of the bed for bed mobility.</p> <p>A quarterly MDS (minimum data set, an assessment completed at periodic intervals of time to determine resident care needs) for Resident CR1 dated [DATE], revealed facility staff assessed the resident as requiring extensive assistance of two people physical assist for bed mobility.</p> <p>Review of a statement dated [DATE], obtained from Employee 1, nurse aide, who was identified as the nurse aide in the room at the time of the incident with Resident CR1 on [DATE], indicated Employee 1 was dressing and cleaning the resident, turned the resident to her side to clean her bottom and fix the pad underneath the resident, and the resident kept yelling about her bottom hurting and kept trying to turn off her side. Employee 1 asked the resident to stop rocking. Employee 1 indicated she got the pad under the resident and when she went to roll the resident towards her the resident said no, and ended up turning toward the nurse aide and fell off the bed noting she tried to catch the resident but was not able to hold onto her. Employee 1 did not indicate any staff were assisting her with providing care to the resident in bed as the resident required.</p> <p>Interview with the Nursing Home Administrator on [DATE], at 10:45 AM revealed that Employee 1 was staffed from a nursing agency and had first worked at the facility on Saturday, [DATE], again on [DATE], and [DATE], the day of the incident with Resident CR1.</p> <p>A review of Employee 1's Quick Start orientation packet for the facility, which included information on abuse and reporting, resident rights, proper body mechanics, and incidents and accidents, was dated [DATE], the employee's second day of work at the facility. The orientation packet did not include any information on how to access the Point of Care system or how to find a resident Kardex in the electronic system to determine resident care needs, which indicate a resident's needed level of assistance for tasks such as bed mobility, eating, transferring, bathing, and ambulation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395825	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Watsontown Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 245 East Eighth Street Watsontown, PA 17777	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Nursing Home Administrator on [DATE], at 1:20 PM revealed that Employee 1 did not complete the orientation packet until [DATE] due to the first day of work ([DATE]th) being a Saturday and confirmed the orientation packet had no information as to where to find or determine a resident's care needs prior to providing care to residents.</p> <p>Review of information submitted by the facility on [DATE], for the above incident regarding Resident CR1 and Employee 1, indicated Employee 1, nurse aide, was providing care to Resident CR1 at the time of the above incident, and while providing care the resident rolled out of bed and sustained multiple fractures. The report indicated Employee 1 was immediately suspended at the time of the incident to complete an investigation, and the facility substantiated neglect had occurred as Employee 1 provided care to the resident independently without the resident's required assistance of two people, despite the fact that the facility failed to provide this information to Employee 1. The facility noted Employee 1 was placed on do not return status with the agency. As further intervention, the facility indicated nurse aides had been educated regarding care on the resident Kardex in Point of Care (system location to find resident care needs) and the agency orientation packet that agency staff complete when starting at the facility would have a bed mobility and transfer status section added to it to identify resident care needs.</p> <p>An observation in the facility on [DATE], at 11:30 AM revealed Employee 2, nurse aide, providing care to residents on the upper level of the facility. In a concurrent interview with Employee 2 she indicated she was agency staff who was called into the facility and arrived at the facility around 8:40 AM. Employee 2 indicated it was the first time she had worked at the facility. Employee 2 stated she was not provided nor completed any orientation packet upon arrival to the facility or prior to providing care to residents in the facility. Employee 2 indicated she was provided a user log in for the Point of Care system but had not logged into it yet, and only knew how to obtain a resident Kardex due to using the same system in another facility she had worked at. Employee 2 was able to demonstrate to the surveyor after multiple attempts to log in to the electronic system how to find a resident Kardex and that it was like another place she had worked.</p> <p>Further review of the facility's follow up to the above incident and interventions facility staff indicated would be implemented in the information submitted revealed the facility did not complete nurse aide and licensed practical nurse education until [DATE], on utilizing the resident's Kardex on the Point of Care system. The facility's current Quick Start orientation packet agency staff are to complete when starting at the facility remained unchanged from the packet Employee 1 signed off as completing on [DATE].</p> <p>Interview with the Nursing Home Administrator on [DATE], at 2:52 PM confirmed no changes had yet been made to the packet to include the information regarding the resident Kardex and Point of Care system to determine resident care needs. The Administrator was made aware agency staff were actively working in the facility and Employee 2 was permitted to start working with residents in the facility without completing an agency orientation packet or any competency that the employee could access information to determine resident care needs prior to her start of work with residents in the facility. The Administrator also confirmed Employee 1 had no record of education or competency on identifying resident care needs prior to the incident, which caused harm to Resident CR1.</p> <p>483.25 (d) Free from accident hazards</p> <p>Previously Cited [DATE]</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395825	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Watsontown Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 245 East Eighth Street Watsontown, PA 17777	

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 - Actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(1)(3)(5) Nursing Services 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights