

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 10/25/2024
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>20725</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident's right to refuse or discontinue advance directive treatment for one of four residents reviewed for advance directive concerns (Resident 80).</p> <p>Findings include:</p> <p>Clinical record review for Resident 80 revealed a POLST (Physician Orders for Life-Sustaining Treatment, portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency) signed by a physician on August 18, 2022, that indicated Resident 80 wanted comfort measures only and should not have hydration or nutrition via a tube. The form did not include a resident or resident representative signature but indicated that verbal consent was obtained via telephone conversation with Resident 80's responsible party.</p> <p>A living will document scanned into Resident 80's electronic medical record signed by Resident 80 on December 1, 2005, designated his responsible party as the agent to carry out his wishes as necessary. The document stipulated that Resident 80 did not want life-sustaining treatment if it prolonged the process of dying, to limit measures to keep him comfortable, and that he did not want tube feeding or any other artificial or invasive form of nutrition or hydration.</p> <p>A physician's order dated August 16, 2022, instructed staff to provide Resident 80 nothing by mouth for dietary intake.</p> <p>A physician's order dated October 18, 2024, instructed staff to feed Resident 80 enterally (via a tube inserted through the abdominal skin into the stomach) every morning and at bedtime for nutrition support.</p> <p>The surveyor reviewed the discrepancy regarding Resident 80's wishes for no artificial nutritional support when his physician ordered enteral feeding during an interview with the Director of Nursing and the Nursing Home Administrator on October 23, 2024, at 2:15 PM.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Social services documentation dated October 24, 2024, at 8:25 AM (following the surveyor's questioning) indicated that staff called Resident 80's responsible party to confirm his POLST form decisions. The documentation indicated that staff were unable to reach the responsible party and left a voicemail.</p> <p>Interview with the Nursing Home Administrator on October 24, 2024, at 2:20 PM indicated that the facility staff began the process of obtaining an updated POLST for Resident 80 to clarify the use of artificial hydration/nutrition via tube. The facility did not provide an updated document as of the conclusion of the onsite survey.</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>20725</p> <p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>Based on clinical record review and staff interview it was determined that the facility failed to provide the required notification timely to a resident whose payment coverage changed for one of three residents reviewed (Resident 65).</p> <p>Findings include:</p> <p>A review of the form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, (a notice that informs the recipient when care received from the skilled nursing facility is ending; and how to contact a Quality Improvement Organization (QIO) to appeal) revealed instructions that a Medicare provider must ensure that the notice is delivered at least two calendar days before Medicare covered services end. The provider must ensure that the beneficiary or their representative signs and dates the NOMNC to demonstrate that the beneficiary or their representative received the notice and understands the termination of services can be disputed. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered. Confirm the telephone contact by written notice mailed on that same date.</p> <p>A review of the Form Instructions Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 revealed that examples of the common reasons why an extended care stay, or services may not be covered under Medicare might include the beneficiary no longer requires daily skilled care for a medical condition but wants to continue residing in the skilled nursing facility (SNF). The SNF enters a good faith estimate of the cost of the corresponding care that may not be covered by Medicare. In the blank that follows Beginning on ., the skilled nursing facility enters the date on which the beneficiary may be responsible for paying for care that Medicare is not expected to cover. The beneficiary selects an option box to indicate a desire to continue to receive the care or not to continue to receive the care and if there is a desire to have the bill submitted to Medicare for consideration. The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The SNF must issue this notice when there is a termination of all Medicare Part A services for coverage reasons. If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered stay.</p> <p>Clinical record review for Resident 65 revealed census documentation that confirmed Resident 65's last covered day of Medicare A services ended September 20, 2024. Resident 65 remained in the facility under a different payment source beginning September 21, 2024.</p> <p>A review of a CMS-10123 form provided by the facility confirmed that Resident 65's last covered day of Medicare A services ended September 20, 2024. The form indicated a conversation with Resident 65's responsible party on September 18, 2024; however, the form did not include any indication that a written copy of the notice was mailed or provided to Resident 65's responsible party. The section of the form that would include a resident or resident representative dated signature was blank.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a CMS-10055 form provided by the facility confirmed that Resident 65's last covered day of Medicare A services ended September 20, 2024, and that financial liability would begin September 21, 2024. The section of the form that would include a resident or resident representative dated signature that the notice was received and understood was blank.</p> <p>The surveyor reviewed the concern that the facility did not provide a signed CMS-10123 or CMS-10055 for Resident 65 during an interview with the Nursing Home Administrator and the Director of Nursing on October 23, 2024, at 3:15 PM.</p> <p>The facility did not provide CMS-10123 or CMS-10055 notices that were signed by the resident's responsible party, evidence that the notices were mailed, or evidence that attempts were made to obtain the necessary signatures on the notices during the onsite survey.</p> <p>28 Pa. Code 201.18(b)(2)(e)(1) Management</p> <p>28 Pa. Code 201.29(a) Resident rights</p>

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<p>F 0584</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 safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738</p> <p>Based on a review of select facility policies and procedures, clinical record review, observations, and resident and staff interview, it was determined that the facility failed to provide a clean, comfortable, homelike environment on two of two nursing units (upper level nursing unit and lower level nursing unit; Resident 53) and failed to exercise reasonable care for the protection of the resident's property from loss for two of 20 residents reviewed (Residents 60 and 102).</p> <p>Findings include:</p> <p>Observation of the upper-level nursing unit shower room on October 25, 2024, at 8:30 AM revealed the following:</p> <p>A shower gurney had a build-up of a dry, white substance and a used resident brief underneath the layer of padding.</p> <p>A handrail located in a resident shower stall was loose and the wall tile was cracked where the handrail met the wall.</p> <p>The above information for the upper-level nursing unit shower room was reviewed with the Nursing Home Administrator on October 25, 2024, at 12:06 PM.</p> <p>Observation of the lower-level nursing unit on October 22, 2024, at 11:10 AM revealed the cove base was off the wall outside of Resident room [ROOM NUMBER]. Observation revealed there were screws exposed.</p> <p>Observation of the locked brief room on the lower-level east nursing unit on October 23, 2024, at 10:03 AM with Employee 1 (licensed practical nurse) revealed that the ceiling tiles were stained with large black areas. Interview with the Nursing Home Administrator on October 23, 2024, at 2:26 PM revealed the black spots appeared to be mold. He stated the kitchen's walk-in freezer is above the brief room and in the spring Department of Safety Inspection (DSI) made the facility remove spray foam under the walk-in freezer, thus causing moisture to accumulate in that area.</p> <p>The above information for the lower-level nursing unit brief room and cove base was reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on October 23, 2024, at 2:06 PM.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's active policy entitled, Inventory of Resident Personal Belongings/Property, revealed that the facility will inventory and record all personal clothing and property belonging to each resident. The purpose of the policy is to identify and record resident belongings at the time of admission and throughout the residents' stay at the facility and assure that the personal belongings are returned to the resident/family upon discharge. The procedures noted in the policy included that all items brought in for the resident must be taken to the receptionist. The receptionist/designee will complete an inventory witnessed by the resident/responsible party (if possible). If the resident or responsible party are unable to witness, two employees will witness the recording via the software. This will be documented in the note section in the software. If the responsible party is not present during inventory an email will be sent to them with the inventory of each item that is logged. The admitting nurse/designee will ensure that any medical assistive devices (i.e., dentures, glasses, hearing aids, etc.) are labeled with the resident's name. When preparing a resident for discharge from the facility, social service/nursing will review the items listed with the resident/responsible party to ensure the belongings/valuables are accounted for. All inventory forms must be reviewed and signed for via the electronic tracking system.</p> <p>Clinical record review for Resident 60 revealed nursing documentation dated September 13, 2024, at 7:37 PM that Resident 60 arrived at the facility, was hard of hearing, and had, .hearing aids in place, can hear with mild difficulty. Wears glasses for reading .</p> <p>A plan of care initiated by the facility on September 13, 2024, to address Resident 60's communication problem and difficulty hearing indicated that he utilized a hearing aid in his left and right ears.</p> <p>A plan of care initiated by the facility on September 13, 2024, to address Resident 60's impaired vision indicated that he wore glasses.</p> <p>Activity staff documentation dated September 18, 2024, at 1:46 PM noted that Resident 60 wore glasses and hearing aids.</p> <p>Nursing documentation dated October 15, 2024, at 12:15 PM indicated that Resident 60 was, .missing his hearing aids on a string and his second pair of eyeglasses. Nursing staff has been instructed to go look through the room with a fine tooth comb. His roommate is agreeable to allow staff to clean the room and go through his things as well in order to be thorough.</p> <p>There was no further documentation in Resident 60's medical record regarding his hearing aids or glasses.</p> <p>Observation and interview with Resident 60 on October 23, 2024, at 10:57 AM revealed he was without his hearing aids. Resident 60 originally stated that he was wearing one in each ear; however, upon further questioning, he confirmed that he did not have them in.</p> <p>Social services late documentation created October 24, 2024, at 9:22 AM (for October 23, 2024, at 9:20 AM) revealed that another skilled nursing facility reported that they had an available bed for Resident 60's admission. The documentation indicated that Resident 60's family would transport him on October 24, 2024, at 8:30 AM.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An attempt to observe Resident 60 on October 24, 2024, at 9:48 AM revealed that he was already discharged from the facility.</p> <p>Interview with Employee 7 (registered nurse/assistant director of nursing/infection preventionist) on October 24, 2024, at 10:35 AM revealed that the facility could not locate Resident 60's personal property documentation.</p> <p>The surveyor reviewed the missing property concerns for Resident 60 during an interview with the Nursing Home Administrator and the Director of Nursing on October 24, 2024, at 2:15 PM. The facility was unable to provide evidence that measures contained in the facility policy to protect resident property from loss or theft were followed for Resident 60 (e.g., evidence that staff inventoried Resident 60's property on admission or upon discharge or investigated and acted upon the report of lost items).</p> <p>Closed clinical record review for Resident 102 revealed that the facility admitted her on July 15, 2024, and discharged her on August 3, 2024.</p> <p>Nursing documentation dated August 3, 2024, at 10:05 AM revealed that staff provided discharge instructions to the resident and her husband and indicated that there was, No inventory sheet to be signed.</p> <p>Interview with the Nursing Home Administrator and the Director of Nursing on October 24, 2024, at 2:15 PM confirmed that the facility had no evidence that staff inventoried Resident 102's personal property on admission or upon discharge as required by the facility policy to assure that personal belongings are returned to the resident/family upon discharge.</p> <p>483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment</p> <p>Previously cited deficiency 11/17/23</p> <p>28 Pa. Code 201.18(b)(3)(e)(2.1) Management</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual 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>18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide a written notice of the facility's bed-hold policy to residents or the residents' responsible parties for five of 13 residents reviewed for hospitalization concerns (Residents 17, 65, 62, 80, and 83).</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 17 was transferred to the hospital on September 28, 2024, after she had a change in condition. There was no documentation available that the facility provided written notice regarding a bed hold to the resident and the resident's responsible party upon transfer out to the hospital.</p> <p>Clinical record review revealed that Resident 65 was transferred to the hospital on September 8, 2024, after he had a change in condition. There was no documentation available that the facility provided written notice regarding a bed hold to the resident and the resident's responsible party upon transfer out to the hospital.</p> <p>The Nursing Home Administrator and Director of Nursing confirmed these findings for Residents 17 and 65 on October 25, 2024, at 10:07 AM.</p> <p>Clinical record review for Resident 62 revealed nursing documentation dated July 9, 2024, at 4:43 PM that he continued with hematuria (blood in the urine), that the certified registered nurse practitioner was made aware, and provided an order to send Resident 62 to the emergency room for evaluation.</p> <p>Nursing documentation dated June 29, 2024, at 4:57 PM indicated that Resident 62 was sent to the emergency room due to hematuria and pain.</p> <p>Nursing documentation dated June 12, 2024, at 11:17 PM revealed that Resident 62 complained of chest pain. Resident 62 requested a transfer to the emergency room for evaluation. Nursing documentation dated June 13, 2024, at 2:19 AM indicated that the hospital admitted Resident 62 for congestive heart failure (insufficient pumping of the heart that affects the body's ability to circulate blood effectively).</p> <p>The surveyor requested evidence that the facility provided the required bed-hold notices to Resident 62's responsible party on the dates of the above noted hospitalization s during an interview with the Nursing Home Administrator and the Director of Nursing on October 24, 2024, at 2:15 PM.</p> <p>Clinical record review for Resident 80 revealed nursing documentation dated September 24, 2024, at 7:51 AM that indicated Resident 80 was having difficulty breathing, had an elevated temperature, and an increased heart rate. The certified registered nurse practitioner provided an order to send Resident 80 to the emergency room for evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nursing documentation dated September 28, 2024, at 4:46 PM revealed that Resident 80 returned to the facility from the hospital.</p> <p>The surveyor requested evidence that the facility provided the required bed-hold notice to Resident 80's responsible party for the above noted hospitalization during an interview with the Nursing Home Administrator and the Director of Nursing on October 24, 2024, at 2:15 PM.</p> <p>Clinical record review for Resident 83 revealed nursing documentation dated August 7, 2024, at 10:50 AM that indicated Resident 83 was short of breath, holding her chest and right flank, was yelling out, and was visibly upset. The facility sent Resident 83 to the emergency room for evaluation. Nursing documentation dated August 7, 2024, at 5:56 PM indicated that Resident 83 returned to the facility with a new diagnosis of a urinary tract infection.</p> <p>Nursing documentation dated July 27, 2024, at 3:45 PM revealed that Resident 83 was experiencing seizure-like activity (spasmic movements of extremities and head) and difficulty maintaining her airway. The facility transferred Resident 83 to the emergency room for evaluation.</p> <p>Nursing documentation dated July 28, 2024, at 12:01 AM revealed that the hospital admitted Resident 83 with a diagnosis of seizures (neurological condition that often results in a temporary loss of consciousness/altered mental status, and spasmic jerking motions of limbs).</p> <p>Nursing documentation dated July 30, 2024, at 3:57 PM indicated that the facility readmitted Resident 83 with diagnoses of a urinary tract infection and seizures.</p> <p>Nursing documentation dated July 31, 2024, at 9:37 AM revealed that staff notified Resident 83's physician that she showed signs of difficulty breathing and her oxygenation assessments were low (percentages in the mid 60's to 70's, normal is greater than 90 percent). She was pale and felt clammy. The facility sent Resident 83 to the emergency room for evaluation.</p> <p>Nursing documentation dated July 31, 2024, at 10:05 PM indicated that the hospital admitted Resident 83 with a diagnosis of syncope (fainting, often caused by a drop in blood pressure).</p> <p>The surveyor requested evidence that the facility provided the required bed-hold notices to Resident 83's responsible party for the above noted hospitalization s during an interview with the Nursing Home Administrator and the Director of Nursing on October 24, 2024, at 2:15 PM.</p> <p>Interview with the Nursing Home Administrator on October 25, 2024, at 8:35 AM, revealed that the facility had no further information regarding the provision of written bed-hold notices to Resident 62, 80, or 83's responsible party.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.29(f) Resident rights</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738</p> <p>Based on clinical record review and staff and resident interview, it was determined that the facility failed to implement a comprehensive person-centered care plan to maintain the highest practicable well-being for two of 20 residents reviewed (Residents 68 and 98).</p> <p>Findings Include:</p> <p>Observation and concurrent interview of Resident 68 on [DATE], at 2:10 PM revealed the resident had an indwelling foley catheter (a device that is inserted into the bladder and drains urine to an external collection bag). The resident's foley catheter drainage collection bag was observed hanging off the dresser located next to the resident's bed.</p> <p>Physician documentation for Resident 68 dated [DATE], revealed the resident had chronic retention of urine with a foley catheter.</p> <p>Current physician orders for Resident 68 revealed the following orders related to the foley catheter:</p> <p>Change the foley catheter and drainage bag monthly and as needed every night shift every one month starting on the 18th and as needed for leaking dated [DATE].</p> <p>Flush the foley catheter with 50 milliliters (ml) of acetic acid (an irrigation solution to help prevent infections) dated [DATE].</p> <p>Document foley output every shift dated [DATE].</p> <p>Review of the current care plan for Resident 68 revealed the resident has bladder incontinence related to dementia and an intervention noted the resident declines to have the foley leg bag switched to a drainage bag overnight with bedtime care.</p> <p>There was no care plan noted for Resident 68 to address the specific care needs associated with the resident's indwelling foley catheter to maintain the highest practicable physical, mental, and psychosocial well-being.</p> <p>The above information for Resident 68 was reviewed with the Nursing Home Administrator on [DATE], at 1:39 PM.</p> <p>Current physician orders for Resident 98 revealed an order dated [DATE], that indicated an advance directive/code status that the resident is a DNR (do not attempt resuscitation and CPR when the person has no pulse and is not breathing) and comfort measures only.</p> <p>The current POLST form (Physician Orders for Life Sustaining Treatment, a legal document that specifies the type of care a person would like in an emergency medical situation) for Resident 98 dated [DATE], indicated the resident was a DNR and specified comfort measures only.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nursing documentation for Resident 98 dated [DATE], at 10:00 AM revealed a new POLST was completed and documented the resident as DNR Comfort Measures Only.</p> <p>Review of the current care plan for Resident 98 revealed an Advance Directive care plan that indicated the resident was a full code (attempt resuscitation and CPR when the person has no pulse and is not breathing). The documentation noted, Advanced Directives and/or POLST must be current and reflect the resident/family/ Responsible Party's decisions. The resident's current decisions are: FULL CODE, no artificial hydration/nutrition.</p> <p>The above information for Resident 98 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on [DATE], at 2:15 PM. The care plan was not updated to reflect the resident's/responsible party's wishes regarding code status of Resident 98 until the care plan was questioned by the surveyor.</p> <p>28 Pa. Code 211.10 (a)(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide shaving support for residents requiring staff assistance for two of two residents sampled for activities of daily living (Residents 65 and 85).</p> <p>Findings include:</p> <p>Observation of Resident 85 on October 22, 2024, at 10:19 AM and October 23, 2024, at 11:21 AM revealed he had several days of facial hair growth on his face. Resident 85 was unable to be interviewed related to his shaving preference due to his current cognitive status.</p> <p>Clinical record review for Resident 85 revealed his admission MDS (Minimum Data Set, an assessment completed at specific interval to determine care needs) dated September 24, 2024, revealed nursing staff assessed him as dependent on staff for his personal hygiene (including shaving).</p> <p>The facility failed to provide Resident 85 shaving assistance.</p> <p>Interview with the Nursing Home Administrator on October 25, 2024, at 11:13 AM confirmed the findings for Resident 85.</p> <p>Observation of Resident 65 on October 22, 2024, at 11:02 AM revealed that he was in bed with several days of facial hair growth on his face. Resident 65 was unable to be interviewed related to his shaving preference due to his current cognitive status.</p> <p>Clinical record review for Resident 65 revealed his most recent annual MDS dated [DATE], noted nursing staff assessed him as requiring partial/moderate assistance (helper does less than half the effort- lifts, holds, or supports trunk or limbs, but provides less than half the effort) for personal hygiene (including shaving).</p> <p>Interview with the Nursing Home Administrator on October 25, 2024, at 11:13 AM, confirmed these findings for Resident 65. The Nursing Home Administrator stated that upon questioning the nurse aides responsible for Resident 65's care revealed that if they hand him the electric razor, he will shave himself with limited help.</p> <p>The facility failed to provide shaving support for Residents 65 and 85, requiring staff assistance for personal hygiene.</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services</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>29512</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered weights and medications for three of 20 residents (Residents 22, 72, and 75).</p> <p>Findings include:</p> <p>Clinical record review for Resident 22 revealed physician orders for staff to administer and complete the following:</p> <p>From August 4, 2023, to September 14, 2024, daily weight every night shift for weight monitoring. Notify physician if given or if weight was greater than 213 (pounds).</p> <p>On September 14, 2024, daily weight every night shift for weight monitoring. Notify physician if given or if weight was greater than 186 (pounds).</p> <p>Both of Resident 22's weight orders indicated that if there was a weight change of greater than 2 pounds in 24 hours or greater than 5 pounds in a week staff were to refer to Resident 22's as needed (PRN) Bumex order for administration.</p> <p>Further review of Resident 22's physician orders revealed the following:</p> <p>From June 13, 2024, to August 12, 2024, Bumex 2 mg (milligrams) PO every 24 hours PRN for weight gain greater than 2 pounds or greater than 5 pounds in a week. Notify physician if given.</p> <p>From August 16, 2024, to September 9, 2024, Bumex 2 mg PO every 24 hours PRN for weight gain greater than 2 pounds or greater than 5 pounds in a week. Notify physician if given.</p> <p>Resident 22's weight orders indicated/referred staff to administer PRN Bumex with weight changes outside the ordered weight parameters, however, there was no PRN Bumex ordered for staff to administer from August 12, 2024, to August 16, 2024, and after September 9, 2024.</p> <p>Review of Resident 22's August, September, and October 2024 MAR (medication administration record, a form to document medication administration) revealed the following:</p> <p>On August 13, 2024, staff documented Resident 22's weight as 198.4 pounds.</p> <p>On August 14, 2024, staff documented Resident 22's weight 204.4 pounds, a six-pound increase in 24 hours.</p> <p>On September 15, 2024, staff documented Resident 22's weight as 176.8 pounds.</p> <p>On September 16, 2024, staff documented Resident 22's weight 178.8 pounds, a two-pound increase in 24 hours.</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>On October 9, 2024, staff documented Resident 22's weight as 167 pounds.</p> <p>On October 10, 2024, staff documented Resident 22, weight as 175.2 pounds, an 8.2-pound increase in 24 hours.</p> <p>There was no documentation that staff identified that there was no PRN Bumex order available when Resident 22 had an identified weight gain on August 14, 2024, September 16, 2024, and October 10, 2024.</p> <p>Review of Resident 22's nursing documentation revealed that staff failed to notify the physician as ordered with a 2 pound in 24 hours or a 5 pound in one week increase in the resident's weight on August 14, 2024, September 16, 2024, and October 10, 2024.</p> <p>The surveyor reviewed the above information during an interview on October 25, 2024, at 8:45 AM with the Director of Nursing.</p> <p>Physician orders for Resident 72 dated April 29, 2024, at 9:00 AM instructed staff to apply a Lidocaine Pain Relief Max St four percent patch to the neck topically in the morning related to cervicgia (a type of neck pain).</p> <p>Review of the October 2024, Medication Administration Record / Treatment Administration Record (MAR/TAR, for Resident 72 revealed that staff had not documented the resident as having received the medication as ordered on October 2, 5 - 21.</p> <p>Review of the clinical documentation for Resident 72 revealed the following MAR and TAR (treatment administration record) notes for the Lidocaine patch:</p> <p>October 2, 2024, at 10:44 AM: Not available</p> <p>October 2, 2024, at 9:22 PM: Not in place</p> <p>October 5, 2024, at 10:33 AM: House stock, not available</p> <p>October 6, 2024, at 10:23 AM: Not available</p> <p>October 7, 2024, at 10:09 AM: Not available</p> <p>October 8, 2024, at 10:54 AM: Not available</p> <p>October 9, 2024, at 10:15 AM: Not available</p> <p>October 9, 2024, at 10:05 PM: Not in place</p> <p>October 10, 2024, at 10:49 AM: on order</p> <p>October 11, 2024, at 10:42 AM: on order</p> <p>October 12, 2024, at 11:29 AM: unavailable</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>October 13, 2024, at 10:06 AM: Not available</p> <p>October 13, 2024, at 9:19 PM: No patch in place due to not available.</p> <p>October 14, 2024, at 10:19 AM: Not available</p> <p>October 15, 2024, at 12:56 PM: waiting for delivery</p> <p>October 16, 2024, at 10:20 AM: Not available</p> <p>October 18, 2024, at 10:43 AM: Not available</p> <p>October 19, 2024, at 10:24 AM: Not available</p> <p>October 20, 2024, at 9:27 PM: Awaiting on delivery for supply room.</p> <p>October 21, 2024, at 9:35 PM: Wasn't in place to remove.</p> <p>There was no documentation noted in the clinical record or provided by the facility that indicated why the medication for Resident 72 was not available for administration or that the medical provider was made aware that the medication was not being administered as per the order.</p> <p>Physician documentation for Resident 75 dated October 1, 2024, revealed an assessment that noted chronic pain syndrome.</p> <p>Physician orders for Resident 75 revealed an order dated July 27, 2024, at 9:00 AM that instructed staff to apply a Lidocaine External five percent patch to the back topically in the morning for pain.</p> <p>Review of the October 2024, MAR/TAR for Resident 75 revealed that staff had not documented the resident as having received the medication as ordered on October 2, and 5-21.</p> <p>Review of the clinical documentation for Resident 75 revealed the following MAR/TAR notes for the Lidocaine patch:</p> <p>October 5, 2024, at 10:34 AM: House stock, not available</p> <p>October 6, 2024, at 10:24 AM: Not available</p> <p>October 7, 2024, at 10:08 AM: Not available</p> <p>October 8, 2024, at 11:02 AM: Not available</p> <p>October 9, 2024, at 10:16 AM: Not available</p> <p>October 10, 2024, at 10:59 AM: on order</p> <p>October 11, 2024, at 10:40 AM: on order</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>October 12, 2024, at 11:27 AM: unavailable</p> <p>October 13, 2024, at 10:07 AM: Not available</p> <p>October 14, 2024, at 10:20 AM: Not available</p> <p>October 15, 2024, at 12:55 PM: waiting for delivery</p> <p>October 16, 2024, at 10:20 AM: Not available</p> <p>October 17, 2024, at 12:32 PM: on order</p> <p>October 18, 2024, at 10:44 AM: Not available</p> <p>October 19, 2024, at 10:25 AM: Not available</p> <p>October 21, 2024, at 10:08 AM: Not available</p> <p>An interview with the Director of Nursing (DON) on October 25, 2024, at 9:15 AM revealed that the facility will have to investigate further to ascertain why the patch for Resident's 72 and 75 was not available for administration as per the physician's order.</p> <p>The above information for Resident's 72 and 75 was reviewed in a meeting with the Nursing Home Administrator on October 25, 2024, at 12:06 PM.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>20725</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to apply a physician ordered splint for one of two residents reviewed for range of motion concerns (Resident 47).</p> <p>Findings include:</p> <p>Clinical record review for Resident 47 revealed an active physician order dated June 28, 2024, that instructed staff to apply a left grip splint in the morning and remove the splint in the evening.</p> <p>A plan of care initiated by the facility on July 22, 2019, to address Resident 47's inability to perform activities of daily living independently related to intellectual disabilities, cerebral palsy (a group of conditions that affect movement and posture caused by brain damage that occurs most often before birth), and impaired mobility, indicated that Resident 47 had contractures (abnormal positioning of a joint) of the left wrist and fingers for which staff were to apply a left grip splint with morning care and remove with evening care.</p> <p>Observation of Resident 47 on the following dates and times revealed that staff did not apply the left-hand splint. The left-hand splint was stored on the bedside furniture in Resident 47's room:</p> <p>October 23, 2024, at 10:38 AM</p> <p>October 24, 2024, at 9:48 AM</p> <p>October 24, 2024, at 11:47 AM</p> <p>Review of Resident 47's treatment administration record (TAR, electronic documentation used by staff to record the completion of treatments) dated October 2024, revealed that staff initialed the application of Resident 47's splint on October 23, 2024, at 9:00 AM, and October 24, 2024, at 9:00 AM.</p> <p>Interview with Employee 6 (licensed practical nurse) during the observation on October 24, 2024, at 11:47 AM revealed that she assumed skilled therapy staff applied Resident 47's left hand splint.</p> <p>Resident 47's clinical record indicated that the left-hand splint was assigned to nursing staff per the TAR documentation.</p> <p>The surveyor reviewed the above concerns regarding Resident 47's left hand splint during an interview with the Nursing Home Administrator and the Director of Nursing on October 24, 2024, at 2:15 PM.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa. Code 211.12(d)(1)(3)(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 - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>20725</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure the application of physician ordered supplemental oxygen consistent with professional standards of practice and the resident's plan of care, for two of two residents reviewed for supplemental oxygen concerns (Residents 47 and 83).</p> <p>Findings include:</p> <p>Clinical record review for Resident 47 revealed an active physician order dated September 12, 2023, for staff to apply supplemental oxygen at 5 liters per minute (lpm) via a cool mist trach collar (air compressor pushes room or oxygenated air through a bottle of sterile water to add moisture to the administered air that is administered through the collar over the tracheostomy tube (artificial opening through which a tube is placed through the front of the neck into the airway to facilitate breathing) to help thin secretions and improve the ability to breathe), titrate (adjust the liter flow) for SPO2 (pulse oximeter, or pulse ox, works by shining a light through the skin and determining the amount of oxygen based on how the light travels through the skin and blood vessels) greater than 93 percent. Obtain SPO2 assessments every shift, every eight hours, for hypoxia (too little oxygen delivered to body tissues).</p> <p>Observation of Resident 47 on the following dates and times revealed he was without a trach collar or supplemental oxygen:</p> <p>October 23, 2024, at 10:39 AM</p> <p>October 23, 2024, at 10:43 AM</p> <p>October 24, 2024, at 9:48 AM</p> <p>October 24, 2024, at 11:44 AM</p> <p>October 25, 2024, at 11:55 AM</p> <p>Review of Resident 47's MAR/TAR dated October 2024, revealed that staff documented his SPO2 was 92 percent (below the 93 percent required per his physician order) on October 23, 2024, at 8:00 AM (day shift). There was only one SPO2 assessment documented on the day shift on October 23, 2024</p> <p>Interview with Employee 6 (licensed practical nurse) on October 24, 2024, at 12:29 PM confirmed that the active physician orders for Resident 47 did not instruct staff to discontinue supplemental oxygen administration if his SPO2 was greater than 93 percent but instructed staff to administer supplemental oxygen at 5 lpm and to titrate (or adjust) the oxygen liter flow to keep oxygen saturations greater than 93 percent.</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 - Some</p>	<p>Interview with the Director of Nursing on October 25, 2024, at 1:22 PM confirmed that Resident 47's medication and treatment administration records (MAR and TAR, electronic documentation completed by staff to record the completion of medications and treatments) dated October 2024, indicated that staff completed the supplemental oxygen treatment as ordered by the physician on October 23 and 24, 2024. The documentation included that the treatment was implemented for eight hours on the first shift on each day. The surveyor reviewed the finding that staff documented Resident 47's SPO2 was below 93 percent on the day shift on October 23, 2024; however, staff did not apply supplemental oxygen.</p> <p>Interview with Employee 6 on October 25, 2024, at 1:23 PM indicated that the eight hours documented on Resident 47's MAR/TAR would indicate the application of supplemental oxygen for eight hours on the shift. When asked to clarify the documentation of the application of supplemental oxygen during hours when Resident 47 did not utilize supplemental oxygen, Employee 6 stated that the eight hours documented could indicate that Resident 47's SPO2 for the eight hours was greater than 93 percent (and not related to how many hours he received supplemental oxygen).</p> <p>Nursing documentation dated October 25, 2024, at 1:09 PM revealed that staff contacted the certified registered nurse practitioner to clarify Resident 47's supplemental oxygen orders. The practitioner changed the order from routine supplemental oxygen to as needed supplemental oxygen that required staff to assess Resident 47's SPO2 every four hours.</p> <p>Clinical record review for Resident 83 revealed an active physician order dated July 30, 2024, for staff to administer supplemental oxygen at 2 lpm as needed for an SPO2 less than 92 percent. Staff were instructed to titrate the oxygen liter flow up or down by one liter as needed to maintain an SPO2 greater than 92 percent. The diagnosis included in the physician order was acute respiratory failure with hypoxia.</p> <p>Review of Resident 83 plans of care developed by the facility to reflect her care needs revealed no focus area pertaining to respiratory failure with hypoxia or interventions that pertained to the use of supplemental oxygen.</p> <p>Review of Resident 83's MAR/TAR dated September and October 2024, revealed that staff did not document an assessment of Resident 83's SPO2 or the administration of supplemental oxygen.</p> <p>Review of vital sign documentation in Resident 83's electronic medical record revealed that staff documented one assessment, on October 16, 2024, at 11:11 AM for September and October 2024.</p> <p>Interview with the Director of Nursing on October 25, 2024, at 1:53 PM confirmed that Resident 83's as needed supplemental oxygen order was based on an assessment of her SPO2; however, there was no evidence that staff obtained SPO2 assessments to determine her potential need for supplemental oxygen as noted above.</p> <p>483.25(i) Respiratory/tracheostomy Care and Suctioning</p> <p>Previously cited deficiency 11/17/23</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>20725</p> <p>Based on review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to assess a residents' need for bed rails, assess risk for entrapment from bed rails, and obtain informed consent before installation of bed rails for two of five residents reviewed for potential accident hazards (Residents 60 and 80).</p> <p>Findings include:</p> <p>The surveyor requested the facility's policies and procedures related to the use of bed rails during an interview with the Nursing Home Administrator and the Director of Nursing on October 24, 2024, at 2:15 PM.</p> <p>The two-page information provided by the facility on October 25, 2024, included a Bed Safety Audit procedure that indicated nursing and maintenance are responsible for conducting Bed Safety Audits. Nursing will follow policy and associated procedures to determine if side rails are clinically indicated.</p> <p>A Bed Entrapment Grid document indicated that the facility identified seven zones of potential resident entrapment as follows:</p> <p>Zone 1, within the rail</p> <p>Zone 2, between the top of a compressed mattress to the bottom of the rail, between rail and supports</p> <p>Zone 3, horizontal space between rail and mattress</p> <p>Zone 4, between top of compressed mattress and bottom of rail at the end of the rail</p> <p>Zone 5, between split rails</p> <p>Zone 6, between rail and edge of head/foot board</p> <p>Zone 7, between head or foot board and mattress</p> <p>The policy/procedure information provided did not include procedures taken to obtain informed consent at the time of the application of bed rails.</p> <p>Clinical record review for Resident 60 revealed a plan of care developed by the facility on September 13, 2024, to address his high risk for falls related to his memory impairment and physical decline that listed interventions that included to offer to place him in bed at 9:00 PM. This intervention was added to Resident 60's plan of care on October 13, 2024, after staff found Resident 60 on the floor following his attempt to self-transfer from his bed to his chair.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of physician orders for Resident 60 revealed no instruction to utilize a bed rail on his bed.</p> <p>Observation of Resident 60's room on October 23, 2024, at 10:45 AM revealed a right-sided bed rail device on his bed. The right side of his bed was positioned against the wall. His bed was equipped with a headboard and a footboard.</p> <p>The surveyor requested the informed consent, assessment for need, and assessment for entrapment risks that the facility completed before installing Resident 60's bed rail during an interview with the Nursing Home Administrator and the Director of Nursing on October 23, 2024, at 2:15 PM.</p> <p>Interview with the Director of Nursing on October 25, 2024, at 12:41 PM revealed that the facility had no evidence that staff obtained consent, or completed assessments for Resident 60's need for, or entrapment risks from, the right-side bed rail on Resident 60's bed. The interview also confirmed that the facility did not obtain a physician's order to utilize a bed rail on Resident 60's bed.</p> <p>Observation of Resident 80's room on October 23, 2024, at 9:18 AM revealed that the bed was equipped with a right-sided bed rail that presented with five openings within the rail. Resident 80's bed was equipped with a footboard and a headboard.</p> <p>Clinical record review for Resident 80 revealed a physician's order dated June 27, 2024, that instructed staff to issue a right-side bed rail for increased independence with bed mobility.</p> <p>Review of a Bed System Measurement Device assessment (worksheet utilized by the facility to document the measurements of applicable potential entrapment zones from the use of a bed rail) dated October 22, 2024, revealed that a bed located on Resident 80's side of his room passed zones two, three, and four for a right-sided bed rail (Resident 80's name was not included on the documentation). The assessment did not include a determination for zone one although there were spaces within the rail mounted on Resident 80's bed. The assessment did not include determinations for zones six and seven although Resident 80's bed was equipped with a headboard and a footboard in combination with a bed rail.</p> <p>Interview with the Nursing Home Administrator and the Director of Nursing on October 24, 2024, at 2:15 PM confirmed the above findings for Resident 80.</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>18229</p> <p>Based on review of facility documentation, employee files, and staff interviews, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of resident tracheostomy, peg tube, and catheter care for four of five employees reviewed (Employees 12, 13, 14, and 15).</p> <p>Findings include:</p> <p>A review of the facility documentation revealed that the facility had five residents with urinary catheters (insertion of a tube into the bladder to remove urine), one resident with a tracheostomy (a surgical airway management procedure that consists of making an incision on the anterior aspect of the neck and opening a direct airway through an incision in the trachea), and two residents with peg tubes (medical procedure in which a tube is passed into resident's stomach through the abdominal wall, most commonly to provide a means of feeding).</p> <p>A request for staff competencies for tracheostomy, peg tube, and catheter care revealed the facility was unable to provide them. Further interview with the Nursing Home Administrator on October 25, 2024, at 11:57 AM revealed that the facility could provide no documentation that ensured Employees 12 (registered nurse), Employee 13 (registered nurse), Employee 14 (licensed practical nurse), and Employee 15 (licensed practical nurse) have the specific competencies and skill sets to care for the residents' needs listed above, or any other competencies.</p> <p>28 Pa Code 201.19(7) Personnel policies and procedures</p> <p>28 Pa Code 211.12 (c)(d)(1)(5) Nursing services</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by two of three residents reviewed (Residents 45 and 65).</p> <p>Findings include:</p> <p>Clinical record review for Resident 45 revealed the facility admitted her on July 26, 2022, with a diagnosis of Alzheimer's dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life). A review of Resident 45's most recent significant change Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated December 1, 2023, indicated that the facility assessed Resident 78 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 45's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss.</p> <p>Clinical record review for Resident 65 revealed that the facility admitted him on November 18, 2022, with diagnoses including dementia with behavioral disturbance. A review of Resident 65's most recent annual MDS dated [DATE], indicated that the facility assessed Resident 65 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 65's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss.</p> <p>The findings were reviewed with the Nursing Home Administrator and Director of Nursing on October 24, 2024, at 2:25 PM. They confirmed that the facility had no further documentation that the facility developed and implemented an individualized person-centered care plan to address Residents 45 and 65's dementia.</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure an appropriate response to consultant pharmacist recommendations for one of five residents reviewed for potentially unnecessary medications (Resident 65).</p> <p>Findings include:</p> <p>Clinical record review for Resident 65 revealed a consultant pharmacist report dated December 4, 2023, requesting the facility evaluate if Resident 65's as needed (PRN) Atarax (antihistamine medication) could be discontinued due to nonuse. Resident 65's physician agreed to the recommendation and staff noted the change on December 6, 2024.</p> <p>Review of Resident 65's physician orders revealed an active order since January 30, 2023, for Atarax 25 milligrams(mg), one tablet every eight hours as needed for itching.</p> <p>Interview with the Director of Nursing on October 25, 2024, at 9:08 AM confirmed the facility failed to respond appropriately to Resident 65's December 4, 2023, pharmacy recommendation, and discontinued his Atarax only after surveyor's questioning.</p> <p>28 Pa. Code 211.9 (k) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>44738</p> <p>Based on observation and resident and staff interview, it was determined that the facility failed to properly secure and account for resident medications and biologicals on one of two nursing units (Upper Level Nursing Unit, Resident 68).</p> <p>Findings include:</p> <p>Observation of Resident 68's room on October 22, 2024, at 2:06 PM revealed the resident was sitting on the edge of the bed. A white, round pill was observed on the floor next to the resident's bed. The resident was unsure where the pill had come from.</p> <p>An interview with Employee 5, licensed practical nurse (LPN), on October 22, 2024, at 2:14 PM revealed the LPN was unable to identify the pill other than the pill was scored. The LPN proceeded to dispose of the medication found on Resident 68's floor.</p> <p>The facility failed to properly secure resident medications as evidenced by an unknown pill found on Resident 68's floor.</p> <p>The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on October 23, 2024, at 3:16 PM.</p> <p>Observation of a medication administration pass with Employee 5 on October 23, 2024, at 8:38 AM revealed the following:</p> <p>Employee 5 retrieved Resident 68's Tramadol 50 milligrams (a controlled medication for pain) from the medication cart, poured the physician ordered dose, and returned the Tramadol medication card to the medication cart. Employee 5 did not verify Resident 68's current Tramadol controlled medication count prior to and after pouring the Tramadol dose with Resident 68's Tramadol controlled medication count log.</p> <p>Interview at 8:45 AM with Employee 5 acknowledged that she was not aware of the facility's-controlled medication policy and procedures, that the facility utilized an electronic controlled medication count, and that the electronic count would change as staff mark administer of the medication upon return to the medication cart.</p> <p>At 8:48 AM, Employee 5 then revealed that there were two Tramadol medication cards for Resident 68 with a total of 34 tablets (4 tablets in one card and 30 tablets in the second card).</p> <p>Employee 5 did not verify Resident 68's Tramadol controlled medication count prior to preparing/pouring the medication to ensure the correct controlled medication count prior to administration.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on October 25, 2024, at 1:03 PM with the Director of Nursing acknowledged the above findings and confirmed that nursing staff are to verify the controlled medication (narcotic) count when preparing the medication for administration.</p> <p>483.45(g)(h)(1)(2) Label/store Drugs and Biologicals</p> <p>Previously cited deficiency 11/17/23</p> <p>28 Pa. Code 211.9(k) Pharmacy services</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>18229</p> <p>Based on clinical record review and resident and staff interview, it was determined that the facility failed to assist a resident in obtaining routine dental services for two of five residents reviewed for dental concerns (Residents 65 and 80).</p> <p>Findings include:</p> <p>Observation of Resident 65 on October 22, 2024, at 11:20 AM revealed that Resident 65 had several broken teeth. Resident 65 was unable to be interviewed due to his current cognitive status.</p> <p>Clinical record review revealed the facility admitted him November 18, 2022, with payment sources that included the state Medicaid benefit.</p> <p>Further review of Resident 65's clinical record revealed that he last saw a dentist on January 10, 2024. A review of this progress note revealed that Resident 65's broken teeth were asymptomatic at that time, and he would be due for his next visit for prophylactic dental cleaning in six months.</p> <p>An interview with Employee 8 (social worker) on October 25, 2024, at 10:46 AM confirmed these findings for Resident 65 and had no further information to indicate that Resident 65 was offered routine dental services every six months as the State plan allows.</p> <p>Interview with Resident 80 on October 23, 2024, at 9:08 AM revealed that he had natural teeth, and he believed that he might have to have a tooth pulled.</p> <p>Clinical record review for Resident 80 revealed a plan of care initiated by the facility on February 17, 2023, to address his oral/dental health problems related to natural dentition, that listed interventions that included:</p> <p>Coordinate arrangements for dental care, transportation as needed/as ordered</p> <p>Resident has natural/own teeth with cavity</p> <p>The surveyor requested any evidence that Resident 80 either received professional dental services since the last standard survey or had refused available dental services during interviews with the Nursing Home Administrator and the Director of Nursing on October 23, 2024, at 2:15 PM, and October 24, 2024, at 2:15 PM.</p> <p>Interview with Employee 8 (director of social services) on October 24, 2024, at 3:01 PM indicated that she would obtain any evidence that Resident 80 received professional dental services.</p> <p>Evidence provided by facility on October 25, 2024, indicated that facility staff forwarded a referral to request dental services for Resident 80 on June 24, 2024; however, the facility provided no evidence that Resident 80 received any professional dental services in the more than 11 months since the facility's last standard survey.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Employee 8 on October 25, 2024, at 10:45 AM confirmed that the facility had no evidence that Resident 80 received professional dental services, or refused those services, in the past year.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 211.15. Dental 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 - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229</p> <p>Based on observation and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection for two of two nursing units (Upper and Lower nursing units, Residents 5, 22, 31, 77, 54, 80, 85, and 47)</p> <p>Findings include:</p> <p>Review of the Centers for Medicare and Medicaid Services (CMS) Quality, Safety, and Oversight Group memo QSO-24-08-NH dated March 20, 2024, entitled Enhanced Barrier Precautions (EBP) in Nursing Homes (NH), revealed the following:</p> <p>EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident activities,</p> <p>EBP are indicated for residents with an infection or colonization with a CDC (Centers for Disease Control) targeted MDRO (multi-drug resistant organism) when contact precautions do not otherwise apply or any wounds and/or indwelling medical devices (a pathway of pathogens in the environment to enter the body and cause infection, such as a urinary catheter) even if the resident is not known to be infected or colonized with a MDRO.</p> <p>Residents identified with EBP needs should have EBP when receiving high-contact resident care activities, such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assist with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator), wound care, and/or any skin opening requiring a dressing, regardless of their multidrug-resistant organism status.</p> <p>Clinical record review for Resident 22 revealed the following physician orders:</p> <p>Enhanced barrier precautions in place every shift for ESBL (extended-spectrum beta-lactamase, an enzyme that makes them resistant to many antibiotics)/Enterococcus coli (E-coli)/Enterococcus in urine.</p> <p>Review of Resident 22's laboratory results dated [DATE], revealed that they were positive for Klebsiella pneumoniae ESBL (severe infection that produces enzymes that break down beta-lactam antibiotics, making them ineffective.)</p> <p>Observation on October 23, 2024, at 12:16 PM of the hallway outside Resident 22's room revealed that there was enhanced barrier precaution signage to indicate the need to utilize PPE (personal protective equipment, to prevent infectious disease transmission) and signage, which indicated the need for EBP. Resident 22 was in a four person bedroom and there were two additional residents (Residents 5 and 31) also located in Resident 22's room. There was no portable commode noted in Resident 22's room or near Resident 22's bed area for their individual use and to mitigate potential transmission of the ESBL identified in her urine.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>This surveyor reviewed the above information during an interview on October 25, 2024, at 8:45 AM with the Director of Nursing.</p> <p>The CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007) revealed that contact (gown and glove use for all care) and standard (glove use only for care likely to contact bodily fluids) isolation precautions are required for multidrug-resistant organisms (MDROs, infections with bacteria that are resistant to multiple commonly used antibiotics; e.g., MRSA (Methicillin-resistant staphylococcus aureus), and ESBLs (bacteria that produces extended-spectrum beta-lactamase that is resistant to commonly used antibiotics), during active infection or colonization (presence of bacteria in the absence of symptoms).</p> <p>Clinical record review for Resident 77 revealed hospital discharge documentation dated March 24, 2024, that indicated that Resident 77 required contact isolation (infection control isolation precautions used to prevent the transmission of infection by contact with potentially infectious surfaces and substances) for ESBL Klebsiella pneumonia in her urine. Documentation of a urine specimen collected March 21, 2024, confirmed that Resident 77's urine was positive for greater than 100,000 colonies of Klebsiella pneumoniae ESBL producing organism. The document specified that, This patient may require isolation.</p> <p>A physician's order dated March 15, 2024, instructed staff to implement droplet/air-borne isolation precautions (isolation precautions that require a gown, gloves, mask, and eye protection for entry into the room) every shift for human metapneumovirus (virus that can cause infections as mild as the common cold or as severe as pneumonia). The order was discontinued on April 1, 2024.</p> <p>A physician's order dated April 15, 2024, (two weeks after the discontinuation of droplet/air-borne isolation), implemented Enhanced Barrier Precautions every shift due to ESBL in Resident 77's urine. The facility discontinued the order on May 29, 2024.</p> <p>A physician's order dated May 29, 2024, reinstated instructions to implement Enhanced Barrier Precautions every shift due to colonization of ESBL in her urine.</p> <p>A Quarterly MDS assessment dated [DATE], assessed Resident 77 as independent with ambulation of 10 to 150 feet, that she utilized a walker, that she was not on a toileting program, but was frequently incontinent of urine.</p> <p>Interview with Resident 77 on October 23, 2024, at 9:44 AM revealed that she takes herself to the bathroom. Resident 77 resided in a room with three other female residents.</p> <p>Interview with Employee 10 (licensed practical nurse, LPN) on October 23, 2024, at 9:42 AM confirmed that Resident 77 required EBP because of noted ESBL in her urine. Employee 10 stated that Resident 77's roommate, Resident 54, uses the bathroom as well as Resident 77.</p> <p>A quarterly MDS assessment dated [DATE], assessed Resident 54 as independent with toileting and ambulation of 10 to 150 feet, that she was occasionally incontinent of urine, but not on a toileting program.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The surveyor requested any laboratory testing that indicated Resident 77 no longer had urinary contamination with the ESBL bacteria during an interview with the Nursing Home Administrator and the Director of Nursing on October 23, 2024, at 2:15 PM.</p> <p>The surveyor repeated the request for information the facility utilized to discontinue the contact isolation precautions for Resident 77 before allowing the use of bathroom facilities for Resident 77 and her potential roommates during an interview with the Nursing Home Administrator and Director of Nursing on October 24, 2024, at 2:15 PM.</p> <p>The facility failed to provide evidence that laboratory testing cleared Resident 77 of ESBL in her urine. The facility was unable to provide evidence that EBP for Resident 77 protected her roommate (Resident 54) from potential exposure to Resident 77's potentially infectious urine. There was no evidence that Resident 54 was also colonized with ESBL to support the cohorting room assignment.</p> <p>Clinical record review for Resident 47 revealed a physician's order dated May 29, 2024, for EBP due to his tracheostomy tube (tube inserted through the neck into the airway to facilitate breathing) and peg tube (tube inserted through the abdominal skin into the stomach for the purposes of instilling fluids, nutrition, and medications).</p> <p>Observation of Resident 47's room on October 23, 2024, at 10:35 AM revealed EBP signage and PPE positioned next to the door to his room.</p> <p>Observation of Resident 47's skin alteration wound treatment on October 25, 2024, at 11:25 AM revealed Employee 6 (LPN) and Employee 11 (nurse aide) donned gloves and entered Resident 47's room to begin care. Neither Employee 6 nor Employee 11 donned an isolation gown. Employees 6 and 11 repositioned Resident 47 several times in his bed to access the wound site of his right lower buttock/upper right leg. Employee 6 and Employee 11 completed all steps of cleansing the wound site, the application of new treatments, the application of an incontinence brief, and repositioning Resident 47 without donning an isolation gown.</p> <p>Interview with Employee 6 on October 25, 2024, at 11:46 AM, confirmed that although she was aware of Resident 47's EBP, she did not don an isolation gown to perform high-contact care.</p> <p>Interview with Employee 11 on October 25, 2024, at 12:38 PM confirmed that although she was also aware of Resident 47's EBP, she did not don an isolation gown to perform high-contact care.</p> <p>The surveyor reviewed the above concerns regarding the maintenance of Resident 47's EBP during an interview with the Director of Nursing on October 25, 2024, at 12:41 PM.</p> <p>Review of the facility's current wound care procedural steps used to complete skilled nursing competency assessments revealed that the procedure included the following:</p> <ul style="list-style-type: none"> Prepare resident properly for treatment Perform hand hygiene and don gloves Remove soiled dressings <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Remove gloves, perform hand hygiene, and don gloves</p> <p>Cleanse site</p> <p>Remove gloves, perform hand hygiene, don gloves</p> <p>Apply treatment, dressings, secure in place</p> <p>Remove gloves and perform hand hygiene</p> <p>Clinical record review for Resident 80 revealed a physician's order dated October 13, 2024, for staff to administer Doxycycline Hyclate (antibiotic), 100 mg (milligrams), two times a day for a left knee wound infection for 10 days.</p> <p>Resident 80's active physician orders instructed staff to implement Enhanced Barrier Precautions related to a peg tube and a wound every shift since May 29, 2024.</p> <p>Observation of Resident 80's room on October 22, 2024, at 12:58 PM revealed that the doorway to his room had signage for both EBP and Contact Precautions.</p> <p>Interview with Employee 10 (LPN) on October 22, 2024, at 1:02 PM indicated that Resident 80 had a peg tube and a wound, so EBP were always in place; however, he currently required Contact Precautions because he was diagnosed with a knee wound infection.</p> <p>Nursing documentation dated July 27, 2024, at 2:11 PM revealed that the physician ordered Doxycycline Hyclate, 100 mg, two times a day for a wound infected with MRSA (Methicillin-Resistant Staphylococcus Aureus, a bacteria that is resistant to commonly used antibiotics).</p> <p>Observation of Resident 80's left knee wound treatment on October 25, 2024, at 11:12 AM revealed Employee 10 donned PPE (to include gloves) to remove the soiled dressings from Resident 80's left knee. The dressing that was removed contained an approximately eraser head-sized area of yellow wound drainage. Employee 10 utilized a spray bottle of wound cleanser to cleanse the wound, applied skin prep (fast-drying sterile liquid that forms a waterproof, breathable barrier on intact or damaged skin) over the wound area, applied an ABD (cushioning gauze that is capable of absorbing increased amounts of drainage) over the wound bed, and secured the dressing with rolled gauze. Employee 10 did not remove her soiled gloves or perform hand hygiene throughout the steps of removing the soiled dressings, cleansing the wound, or applying the new dressings.</p> <p>Interview with Employee 10 on October 25, 2024, at 11:23 AM confirmed that she was to perform hand hygiene between the steps of the wound care; however, she forgot to do so.</p> <p>The surveyor reviewed the above concerns regarding Resident 80's wound care during an interview with the Director of Nursing on October 25, 2024, at 12:41 PM.</p> <p>Clinical record review revealed the facility admitted Resident 85 on September 13, 2004, with a suprapubic catheter. Review of Resident 85's physician orders revealed an order for enhanced barrier precautions initiated September 13, 2024.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Watsontown Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 245 East Eighth Street Watsontown, PA 17777	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of Resident 85 on October 22, 2024, at 9:47 AM and October 23, 2024, at 10:30 AM revealed that he was in his room and there was no signage for enhanced barrier precautions or PPE outside of his room.</p> <p>Findings for Resident 85 were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on October 23, 2024, at 2:08 PM. They confirmed these findings for Resident 85.</p> <p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control</p> <p>Previously cited deficiency 1/24/24 and 11/17/23</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738</p> <p>Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure a resident received the pneumococcal immunization for one of five residents reviewed for immunization concerns (Resident 96).</p> <p>Findings include:</p> <p>Review of the policy entitled Pneumococcal Vaccine Guidelines, last reviewed without changes in August 2024, revealed that the facility will offer residents the pneumococcal vaccine to aid in preventing pneumococcal infections as applicable per physician order. The procedure noted that previous immunization information will be requested during the pre-admission process. A representative from the admissions office/designee will obtain and forward copies of the immunization records to the admitting nurse. Verify the data with the resident and/or authorized representative when applicable. The pre-admission immunizations will be added to the electronic immunization record/EMR. The immunization record/EMR will be updated with each offer (administrations and refusals) of the pneumococcal vaccine. Each age-appropriate and/or diagnosis appropriate resident will be offered a pneumococcal vaccination per physician order, to minimize the risk of acquiring, transmitting, or experiencing complications from pneumococcal pneumonia; unless the vaccine is medically contraindicated, or the resident has already been vaccinated within the designated timeframe.</p> <p>Clinical record review for Resident 96 revealed the resident was admitted to the facility on [DATE].</p> <p>Facility documentation titled, Resident Pneumococcal and Influenza Immunization Consent/Declination, noted that the pneumococcal immunization status of all residents will be determined on admission regardless of date of admission. Vaccination will be offered to residents who cannot provide documentation of previous vaccination. Those who are unsure of their vaccination status and consent to the vaccine will receive the vaccine. The form was signed by Resident 96's responsible party and dated July 11, 2024. However, there were no documented previous immunizations noted in the designated section on the form. The areas marked for consent or declination of the vaccine were not marked as the resident/responsible party either consenting to or refusing the vaccine.</p> <p>Review of the immunizations for Resident 96 revealed no evidence of a pneumococcal immunization for the resident, pneumococcal vaccination history, or any offers/refusals/contraindications to the vaccination.</p> <p>A request for any information relating to Resident 96's pneumococcal vaccination was made by the surveyor to Employee 7, Infection Preventionist, on October 24, 2024, at 12:30 PM and revealed no further documentation (such as any refusals, consents, vaccine history) was provided.</p> <p>An interview with the Director of Nursing on October 25, 2024, at 1:15 PM regarding Resident 96's immunizations revealed that there is an upcoming immunization clinic, and the facility is in the process of making phone calls to determine how many residents want the offered immunizations. However, the facility was unable to provide any type of written consent, refusals, or vaccine history for Resident 96.</p> <p>(continued on next page)</p>		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738</p> <p>Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to offer, or provide education regarding the benefits, risks, and potential side effects with the COVID vaccine for one of five residents reviewed for immunizations (Resident 96).</p> <p>Findings include:</p> <p>Review of the policy titled COVID-19 Vaccination Administration, last reviewed in August 2024, indicated that, The facility will offer and administer COVID-19 vaccinations in accordance with state and federal guidelines. The vaccination schedule in the policy noted, The COVID vaccination schedules for people who are not moderately or severely immunocompromised and people who are moderately or severely immunocompromised should be consulted for age-specific information.</p> <p>Clinical record review for Resident 96 revealed the resident was admitted to the facility on [DATE].</p> <p>Review of the immunizations for Resident 96 revealed no evidence of a COVID vaccination for the resident, vaccination history, or any offers/refusals/contraindications to the vaccination.</p> <p>A request for any information relating to Resident 96's COVID vaccination was made by the surveyor to Employee 7, Infection Preventionist, on October 24, 2024, at 12:30 PM revealed no further documentation (such as any refusals, consents, vaccine history) was provided.</p> <p>An interview with the Director of Nursing on October 25, 2024, at 1:15 PM regarding Resident 96's immunizations revealed that there is an upcoming immunization clinic, and the facility is in the process of making phone calls to determine how many residents want the offered immunizations. However, the facility was unable to provide any type of written consent, refusals, or vaccine history for Resident 96.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>44738</p> <p>Based on observation and staff interview, it was determined that the facility failed to ensure a safe and clean environment in the facility main laundry area located on the lower level.</p> <p>Findings include:</p> <p>Observation of the facility's main laundry area on October 25, 2024, between 8:40 AM to 8:55 AM revealed the following:</p> <p>A soiled linen room that contained a large laundry bin on wheels with an extensive build-up of debris in the bottom that included paper products, dirt, balled up gloves, and at least two washcloths.</p> <p>An active vent blowing air into the soiled area had an extensive build-up of dust on it.</p> <p>A commode with no lid on the bowl had debris and paper products discarded in the bowl. Three pillows and other items were set on top of the lidless bowl.</p> <p>There were multiple cobwebs hanging from the ceiling at the perimeter where the ceiling met the wall.</p> <p>The clean linen area of the laundry had a ceiling tile missing next to a fluorescent light fixture that was powered off. There were multiple pipes and wires visible. At least three ceiling tiles had large brown colored water stains on them. A large plastic garbage container and a bucket were underneath the area and partially filled with water that dripped from the ceiling. Three blankets were also on the floor to collect the water. A concurrent interview with Employee 9, laundry aide, revealed the ceiling has been leaking for one month when residents utilize the showers, which are located above the area.</p> <p>Observation of the area where the clothes are washed and dried revealed the following:</p> <p>An electric heater affixed to the ceiling in the corner of the room had a large black/brown colored stain above it on the ceiling tile that had white fuzzy areas throughout the stained portion.</p> <p>A blood spill compliance center attached to the wall had various kits labeled protective packs. There was an extensive build-up of dust on both the plastic container and the kits.</p> <p>An insect glue trap located on the electrical box was covered with a significant amount of dust.</p> <p>The findings for the laundry area were reviewed with the Nursing Home Administrator (NHA) on October 25, 2024, at 12:09 PM. The NHA further noted the facility is attempting to obtain a quote for repairs for the leak, but the quote has not been acquired yet.</p> <p>28 Pa. Code 201.18 (b)(1)(3) Management</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>18229</p> <p>Based on review of employee education records and staff interview, it was determined that the facility failed to ensure that nurse aides received 12 hours of in-service training annually for three of three nurse aides reviewed (Employees 2, 3, and 4).</p> <p>Findings include:</p> <p>During a meeting with the Nursing Home Administrator and Director of Nursing on October 23, 2024, at 2:21 PM the surveyor asked for training records to indicate that nurse aides had received at least 12 hours of in-service training in the last year for Employees 2, 3, and 4 (nurse aides).</p> <p>Interview with the Nursing Home Administrator on October 25, 2023, at 11:41 AM confirmed there was no documented evidence that the above employees received the required 12 hours of annual in-service training.</p> <p>483.95(g) Required in-service training for nurse aides.</p> <p>Previously cited deficiency 11/17/23</p> <p>28 Pa. Code 201.19 (7) Personnel policies and procedures</p>