

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395847	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/19/2024
NAME OF PROVIDER OR SUPPLIER Montgomery Subacute and Respiratory Center		STREET ADDRESS, CITY, STATE, ZIP CODE 251 Stenton Avenue Plymouth Meeting, PA 19462	
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 0575</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency.</p> <p>51165</p> <p>Based on observations and interview with staff and residents, it was determined that the facility failed to post contact information for the Pennsylvania Department of Health and the State Long-Term Care Ombudsman program as required for one of four nursing units that was accessible to residents. (First floor B)</p> <p>Findings include:</p> <p>During resident council meeting held July 16, 2024 at 11:15 a.m. revealed 5 of 7 residents were unaware of where the State Department of Health contact information or the State Long-Term Care Ombudsman program contact information was posted. Residents stated they did not recall signs with the information posted in the facility.</p> <p>Observations conducted on July 16, 2024 at 12:15 pm on each nursing floor of the facility revealed that the facility did not have the State Department of Health contact information available and accessible to residents on first floor B nursing unit. Floor B failed to post the State Department of Health contact information on the bulletin board. Further observation revealed the State Long-Term Care Ombudsman program contact information was posted in Spanish on the bulletin board for residents. The State Long-Term Care Ombudsman program contact information in English was posted behind the nursing station, which made it inaccessible for residents.</p> <p>An interview was conducted with Employee E4, Regional Nurse, on July 16, 2024 at 12:30 p.m. and confirmed the required contact information was not available and accessible to residents on Floor B.</p> <p>28 Pa. Code: 201.14(a)Responsibility of licensee</p> <p>28 Pa. Code: 201.18(e) Management</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>41471</p> <p>Based on review of clinical records, review of facility policies and procedures and interviews with staff, it was determined that the facility failed to promptly notify a resident's representative and physician of a skin impairment for one of 15 residents reviewed. (Resident R28).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of an undated facility policy titled Change in a Resident's Condition or Status, revealed <ol style="list-style-type: none"> a. The nurse will notify the resident's attending physician or physician on call when there has been a(an) <ol style="list-style-type: none"> b. accident or incident involving the resident; c. discovery of injuries of an unknown source; d. adverse reaction to medication; e. significant change in the resident's physical/emotional/mental condition; f. need to alter the resident's medical treatment significantly; g. refusal of treatment or medications two (2) or more consecutive times); h. need to transfer the resident to a hospital/treatment center; i. discharge without proper medical authority; and/or j. specific instruction to notify the physician of changes in the resident's condition. 4. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when: <ol style="list-style-type: none"> e. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; f. There is a significant change in the resident's physical, mental, or psychosocial status; g. There is a need to change the resident's room assignment; h. A decision has been made to discharge the resident from the facility; and/or i. It is necessary to transfer the resident to a hospital/treatment center. <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident R28's wife on July 19, 2024, at 1:10 p.m. stated back in April she saw a bump and a cut with dried blood in the middle of the bump on resident's forehead. She stated resident did not have any brace or hard surface next to the injury when she saw it. She stated she was concerned about the injury and was upset that the facility did not notify her about the injury before she identified.</p> <p>Review of facility investigation dated April 18, 2024, revealed that Resident R48's wife reported to the Life Enrichment Director and Director of Nursing that her husband had a skin tear noted on his forehead. The Director of Nursing immediately assisted the resident back to his room to assess the skin tear. The skin tear was noted to be 4 centimeters (cm) long and 0.5cm wide with a red base and pink surrounding area. The resident's wife expressed concern and stated she wanted the resident to be sent to the Emergency Department for evaluation and treatment. The resident's physician was called to inform of the new skin condition for the resident and gave the order for the resident to be transferred to the Emergency Department. The wound care nurse and nurse supervisor also assessed the resident and noted the skin tear above the left eyebrow.</p> <p>Investigation also revealed that facility interviewed and obtained statements from the nurse and the nurse aide the night before the injury was reported.</p> <p>Review of statements from Employee E8, Licensed Practical Nurse, who worked on 7:00 p.m. to 7:00 a.m. shift of April 17, 2024, revealed that she did not observe any injury to Resident R28.</p> <p>Review of statements from Employee E9, Nurse Aide, who worked on 7:00 p.m. to 7:00 a.m. shift of April 17, 2024, revealed that she did observe injury to Resident R28 and reported to Employee E10, Licensed Practical Nurse.</p> <p>Review of statements from Employee E10 Licensed Practical Nurse, who worked on 7:00 p.m. to 7:00 a.m. shift of April 17, 2024, revealed that he was notified by the aide to a wound on Resident R28's forehead. He observed that the resident had a dark brown patch on the right side of the forehead. He was not assigned to the resident so he thought the aide would pass the information to resident's nurse.</p> <p>Review of statements from Employee E11, Nurse Aide, who worked on 7:00 a.m. to 7:00 p.m. shift of April 18, 2024, revealed that soon after she provided care to Resident R28 she noticed he had a red spot on his head. The area was dry. However, the statement did not reveal any evidence that she reported this to the nurse or the supervisor.</p> <p>Observation of an image of resident's injury with the administrator revealed that the resident had a red colored skin impairment to the forehead with the surrounding area had raised skin, appeared like swelling.</p> <p>Review of Resident R1's entire clinical record revealed no documented evidence that Resident R28's physician was notified when the Employee E9 observed the skin impairment on April 17, 2024, 7:00 p.m. to 7:00 a.m. shift and when Employee E11 observed the skin impairment on April 18, 2024</p> <p>Review of Resident R1's clinical record also revealed no documented evidence that Resident R28's responsible party was notified when the Employee E9 observed the skin impairment on April 17, 2024, 7:00 p.m. to 7:00 a.m. shift and Employee E11 observed the skin impairment on April 18, 2024</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Director of Nursing, Employee E2, on July 19, 2024, at 2:00 p.m. confirmed that the facility documentation did not reveal evidence that the Resident R1's responsible party and physician was notified of Resident R28's skin impairment when it first observed by Employee E9 and later when Employee E11 observed the skin impairment.</p> <p>28 Pa. Code 201.29(a) Resident Rights</p> <p>28 Pa. Code 211.12(d)(3) 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>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>46508</p> <p>Based on review of clinical records and facility documentation and interview with staff, it was determined that the facility failed to provide the required advance notice through a Notice of Medicare Non-Coverage related to the termination of Medicare services for three of three residents reviewed (Resident R166, Resident R167 and Resident R35).</p> <p>Findings include:</p> <p>Review facility policy on Medicare Advance Beneficiary and Medicare Non-coverage Notices revealed that under section Policy Statement, Residents are informed in advance when changes will occur to their bills. Under section Policy Interpretation and Implementation. Skilled Nursing Facility Advance Beneficiary Notice (CMS form 10055) # 1. If the director of admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). #2. The facility issues the Skilled Nursing Facility Advance Beneficiary Notice (CMS form 10055) for the following triggering events: Initiation - In the situation in which the director of admissions or benefits coordinator believes Medicare will not pay for extended care items or services that a physician has ordered, a SNFABN is issued to the beneficiary before those non-covered extended care items or services are furnished to the beneficiary., Reduction - In the situation in which the facility proposes to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay for a subset of extended care items or services, or for any items or services at the current level and/or frequency of care that a physician has ordered, the SNFABN is issued to the beneficiary before items or services to the beneficiary are reduced., Termination - In the situation in which the facility proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF ABN is issued to the beneficiary before such extended care items or services are terminated.</p> <p>#3. The resident (or representative) is informed that they may choose to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. Notice of Medicare Non-Coverage (CMS form 10123) #1. If the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-Coverage (CMS form 10123) is issued to the resident at least two calendar days before benefits end. #2. The Notice of Medicare Non-Coverage informs the resident of the pending termination of coverage and of his/her right to an expedited review by a Quality Improvement Organization. #3. The Notice of Medicare Non-Coverage is not given if: #a. the beneficiary exhausts the SNF benefits coverage (100 days), thus exhausting their Medicare Part A SNF benefit; #b. the beneficiary initiates the discharge from the SNF; or #c. the beneficiary elects the hospice benefit or decides to revoke the hospice benefit and return to standard Medicare coverage.</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>Review of the list of residents were discharged from a Medicare covered part A stay with benefit days remaining in the past six months revealed that Resident R166, Resident R167 and Resident R35 were discharged from a Medicare covered part A stay with benefit days remaining.</p> <p>Interview with Regional Administrator, Employee E7 conducted on July 19, 2024, at 9:12 a.m. confirmed that Resident R166, Resident R167 and Resident R35 were discharged from a Medicare covered part A stay with benefit days remaining during the past six months. Further Employee E7 revealed that the facility did not provide the Resident R166, Resident R167 and Resident R35 or their responsible parties with a notification of termination of services under Medicare covered part A.</p> <p>Further interview with Employee E7 revealed that the business office person was not aware that a notice of Medicare non-coverage had to be sent to family members or residents who were discharged from a Medicare covered part A stay with benefit days remaining.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0585</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 voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>41471</p> <p>Based on observation, facility policy review, staff and residents' interview, it was determined that the facility failed to provide residents access to grievance information on two out of three nursing units. (2nd floor and First floor Stenton unit).</p> <p>Findings include:</p> <p>A review of an undated facility policy and procedure titled, Grievances/Complaints. Filing, indicated Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the State Ombudsman).</p> <p>Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously.</p> <p>During the resident council group meeting that was held on February 27, 2024, at 10:37 a.m. with 7 alert and oriented residents (R11, R36, R24, R6, R8, R23 and R20) reported that they were not aware of the facility grievance process and how to file grievances. Residents also stated they did know how to access grievance forms and file grievances anonymously.</p> <p>An interview and observation on July 17, 2024, at 12:15 p.m., with Regional Nurse, Employee, E4, it was revealed that there were no grievance forms or grievance instruction available on both side of the First floor Stenton unit. On the Second-floor nursing unit there were no grievance forms or grievance instruction were available on the unit. First floor Stenton unit and second floor unit did not have any availability for residents to file an anonymous grievance.</p> <p>28 Pa. Code 201.18(b)(2) Management</p> <p>28 Pa. Code 201.29(a)(i) Resident rights</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on review of facility policy, review of clinical records and staff interview, it was determined that the facility did not ensure that residents were free of misappropriation of resident property related to diversion of a narcotic medication for five of five residents prescribed narcotic medications. (Resident R18, Resident R49, Resident R29, Resident R165, Resident R21)</p> <p>Findings include:</p> <p>Review of facility policy on Abuse, Neglect, Exploitation and Misappropriation Prevention Program revealed that under section Policy Statement, residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes, but is not limited to, freedom from corporal punishment and voluntary seclusion, verbal, mental, sexual, or physical abuse and physical or chemical restraint not required to treat the resident's symptoms. Under a section Policy Interpretation and Implementation The Resident Abuse, Neglect and Exploitation Prevention Program consists of a facility wide commitment and resource allocation to support the following objectives. #1 Protect resident from abuse, neglect, exploitation, or misappropriation of property by anyone, including but not necessarily limited to: #a. facility staff. #b other residents #c. consultants. #d. volunteers. #e. Staff from other resident agencies #f. family members #g. legal representatives #h. friends #i. visitors and or #j. any other individual.</p> <p>Review of Resident R18's clinical record revealed that Resident R18 was admitted to the facility on [DATE], with diagnoses of Chronic Respiratory Failure, Muscle Weakness, Major Depressive Disorder, and pain in unspecified joint.</p> <p>Further review of Resident R18's clinical record revealed a physician order for the narcotic medication Oxycodone HCl Oral Tablet 5 milligrams (mg) by mouth, every six hours as needed for moderate pain, related to unspecified joint pain.</p> <p>Review of Resident R18's Narcotic count/accountability record for Oxycodone 5 mg 1 tab every 6 hours PRN revealed that the dates were scribbled over for April 8, 9, and 10 2024.</p> <p>On April 10, 2024, there were 28 tablets on hand, 2 tablets were removed leaving 26 tablets. Review of Resident R18's April 2024 MAR (Medication Administration Record) revealed no documented evidence that Oxycodone 5 mg was given to Resident R18 on April 10, 2024.</p> <p>On April 11, 2024, there were 26 tablets on hand, 2 tablets were removed, leaving 24 tablets. Review of Resident R18's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R18 on April 11, 2024.</p> <p>On April 12, 2024, there were 24 tablets on hand, 2 tablets were removed leaving 22 tablets. Review of Resident R18's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R18 on April 12, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On April 15, 2024, there were 17 tablets on hand, 2 tablets were removed leaving 15 tablets. Review of Resident R18's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R18 on April 15, 2024.</p> <p>On April 18, 2024, there were 13 tablets on hand. 1 tablet was removed leaving 12 tablets. Review of Resident R18's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R18 on April 18, 2024.</p> <p>On April 20, 2024, there were 9 tablets on hand, 4 tablets were removed, leaving 5 tablets. Review of Resident R18's April 2024 MAR revealed that Oxycodone 5 mg was given to Resident R18 one time (7am) on April 18, 2024.</p> <p>On April 21, 2024, there were 30 tablets on hand. 10 tablets were removed leaving 20 tablets. Review of Resident R18's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R18 on April 21, 2024.</p> <p>On April 26, 2024, there were 18 tablets on hand. 2 tablets were removed leaving 16 tablets. Review of Resident R18's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R18 on April 26, 2024.</p> <p>On April 29, 2024, there were 16 tablets on hand. 1 tablet was removed leaving 15 tablets. Review of Resident R18's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R18 on April 29, 2024.</p> <p>On April 30, 2024, there were 15 tablets on hand. 1 tablet was removed leaving 14 tablets. Review of Resident R18's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R18 on April 30, 2024.</p> <p>On May 2, 2024, there were 14 tablets on hand. 2 tablets were removed leaving 12 tablets. Review of Resident R18's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R18 on May 2, 2024.</p> <p>On May 3, 2024, there were 12 tablets on hand. 2 tablets were removed leaving 10 tablets. Review of Resident R18's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R18 on May 3, 2024.</p> <p>On May 4, 2024, there were 10 tablets on hand. 5 tablets were removed leaving 5 tablets. Review of Resident R18's May 2024 MAR revealed that Oxycodone 5 mg was given to Resident R18 on one time (7:53am) on May 4, 2024.</p> <p>On May 5, 2024, there were 5 tablets on hand. 5 tablets were removed leaving 0 tablet. Review of Resident R18's May 2024 MAR revealed that Oxycodone 5 mg was given to Resident R18 one time (7:53am) on May 5, 2024.</p> <p>Review of Resident R21's clinical record revealed that Resident R21 was admitted to the facility on [DATE], with diagnoses of Chronic Respiratory Failure, Anoxic Brain Damage, Type 2 Diabetes Mellitus, Anxiety Disorder, Cognitive Communication Disorder, Depression, Schizophrenia, and Pain Unspecified.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident R21's clinical record revealed a physician order for Oxycodone Hydrochloride oral tablet. 5 milligrams, give 5 milligrams by mouth every six hours as needed for pain moderate pain.</p> <p>On April 30, 2024, there were 26 tablets on hand, 1 tablet was removed leaving 25 tablets. Review of Resident R21's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R21 on April 30, 2024.</p> <p>On May 1, 2024, there were 25 tablets on hand, 3 tablets were removed leaving 22 tablets. Review of Resident R21's May 2024 MAR revealed that Resident R21 received Oxycodone 5 mg one time (9:09 a.m.) on May 1, 2024.</p> <p>On May 4, 2024, there were 20 tablets on hand, 3 tablets were removed leaving 17 tablets. Review of Resident R21's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R21 on May 4, 2024.</p> <p>On May 5, 2024, there were 17 tablets on hand, 4 tablets were removed leaving 13 tablets. Review of Resident R21's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R21 on May 5, 2024.</p> <p>On May 6, 2024, there were 13 tablets on hand, 2 tablets were removed leaving 11 tablets. Review of Resident R21's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R21 on May 6, 2024.</p> <p>On May 7, 2024, there were 11 tablets on hand, 2 tablets were removed leaving 10 tablets. Review of Resident R21's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R21 on May 7, 2024.</p> <p>Review of Resident R29's clinical record revealed that Resident R29 was admitted to the facility on [DATE], with diagnoses of Chronic Respiratory Failure, Unspecified Injury of the Head, Unspecified Pain, Muscle Weakness, Tracheostomy Status, Other Muscle Spasm, Cognitive Communication Deficit, Functional Quadriplegia.</p> <p>Further review of Resident R29's clinical record revealed a physician order for Oxycodone Hydrochloride oral tablet 5 milligrams, give 5 milligram via G tube (gastro intestinal tube feeding) every six hours as needed for pain related to unspecified pain.</p> <p>On April 20, 2024, there were 18 tablets on hand, 2 tablets were removed leaving 16 tablets. Review of Resident R29's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R29 on April 20, 2024.</p> <p>On April 21, 2024, there were 16 tablets on hand, 1 tablet was removed leaving 15 tablets. Review of Resident R29's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R29 on April 21, 2024.</p> <p>On April 30, 2024, there were 15 tablets on hand, 1 tablet was removed leaving 14 tablets. Review of Resident R29's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R29 on April 30, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On May 2, 2024, there were 14 tablets on hand, 1 tablet was removed leaving 13 tablets. Review of Resident R29's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R29 on May 2, 2024.</p> <p>On May 5, 2024, there were 12 tablets on hand, 2 tablet were removed leaving 10 tablets. Review of Resident R29's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R29 on May 5, 2024.</p> <p>On May 6, 2024, there were 10 tablets on hand, 2 tablet were removed leaving 8 tablets. Review of Resident R29's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R29 on May 6, 2024.</p> <p>On May 7, 2024, there were 8 tablets on hand, 2 tablet were removed leaving 6 tablets. Review of Resident R29's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R29 on May 7, 2024.</p> <p>Review of Resident R49's clinical record revealed that Resident R49 was admitted to the facility on [DATE], with diagnoses of Acute Respiratory Failure, Type two Diabetes Mellitus, Cognitive Communication Deficit, Pain in unspecified, Major Depressive Disorder.</p> <p>Further review of Resident R49's clinical record revealed a physician order for Oxycodone oral tablet 10 milligrams give 10 milligrams via G tube every six hours as needed for pain.</p> <p>On April 25, 2024, there were 24 tablets on hand, 3 tablets were removed leaving 21 tablets. Review of Resident R49's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R49 on April 25, 2024.</p> <p>On April 26, 2024, there were 21 tablets on hand, 3 tablets were removed leaving 18 tablets. Review of Resident R49's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R49 on April 26, 2024.</p> <p>On April 27, 2024, there were 18 tablets on hand, 1 tablet was removed leaving 17 tablets. Review of Resident R49's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R49 on April 27, 2024.</p> <p>On April 28, 2024, there were 17 tablets on hand, 2 tablets were removed leaving 15 tablets. Review of Resident R49's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R49 on April 28, 2024.</p> <p>On April 29, 2024, there were 15 tablets on hand, 2 tablets were removed leaving 13 tablets. Review of Resident R49's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Reside R49 on April 29, 2024.</p> <p>On April 30, 2024, there were 13 tablets on hand, 2 tablets were removed leaving 11 tablets. Review of Resident R49's April 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R49 on April 30, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On May 1, 2024, there were 11 tablets on hand, 1 tablet was removed leaving 10 tablets. Review of Resident R49's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R49 on May 1, 2024.</p> <p>On May 2, 2024, there were 10 tablets on hand, 1 tablet was removed leaving 19 tablets. Review of Resident R49's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R49 on May 2, 2024.</p> <p>On May 3, 2024, there were 9 tablets on hand, 1 tablet was removed leaving 8 tablets. Review of Resident R49's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R49 on May 3, 2024</p> <p>Review of Resident R165's clinical record revealed that Resident R165 was admitted to the facility on [DATE], with diagnoses of acute and chronic respiratory failure, Pain, Chronic obstructive pulmonary disease, Cognitive communication deficit.</p> <p>Further review of Resident R165's clinical record revealed a physician order for Oxycodone Hydrochloride oral tablet. 5 milligrams. Give 5 milligrams via G tube every eight hours as needed for pain. 5-10</p> <p>On May 4, 2024, there were 12 tablets on hand, 6 tablet were removed leaving 6 tablets. Review of Resident R165's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R165 on May 4, 2024.</p> <p>On May 5, 2024, there were 6 tablets on hand, 4 tablet were removed leaving 2 tablets. Review of Resident R165's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R165 on May 5, 2024.</p> <p>On May 6, 2024, there were 2 tablets on hand, 1 tablet were removed leaving 1 tablet. Review of Resident R165's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R165 R18 on May 6, 2024.</p> <p>On May 6, 2024, there were 12 tablets were received plus 1 tablet- total of 13 tablets on hand.</p> <p>On May 6, 2024, there were 13 tablets on hand, 2 tablet were removed leaving 11 tablets. Review of Resident R165's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R165 on May 6, 2024.</p> <p>On May 7, 2024, there were 11 tablets on hand, 2 tablet were removed leaving 9 tablets. Review of Resident R165's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R165 on May 7, 2024.</p> <p>On May 8, 2024, there were 9 tablets on hand, 1 tablet were removed leaving 8 tablets. Review of Resident R165's May 2024 MAR revealed no documented evidence that Oxycodone 5 mg was given to Resident R165 on May 8, 2024.</p> <p>Further observation of the narcotic accountability book, dates and the number of counts were scribbled over.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Director of Nursing, Employee E2 conducted on July 19, 2024, at 1:49 PM confirmed that there were multiple missing Oxycodone tablets from multiple residents over several days for the month of April and May 2024. Further Employee E2 revealed that based on their investigation, it was determined that the Oxycodone tablets were missing during the shifts when a particular nurse was on duty.</p> <p>28 Pa. Code 201.18(b)(2) Management</p> <p>28 Pa. Code 211.12 (d)(1)(3) Nursing services</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on observation, a review of select facility's policy, clinical records review, and staff interviews, it was determined that the facility failed to ensure the evaluation of resident's need and use of restraints, including evaluation of the least restrictive measure needed to treat the resident's medical symptom and failed to obtain informed consent prior to the use of restraint for two of two sampled residents with residents reviewed. (Residents R22 and R56)</p> <p>Findings include:</p> <p>A review of a facility policy titled Use of Restraints -, revised on April 2017 revealed Use of Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully.</p> <p>Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls</p> <p>When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented.</p> <p>Physical Restraints' are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.</p> <p>Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor).</p> <p>Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms.</p> <p>Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use.</p> <p>Review of facility documentation (Informed Consent for the use of Restraint revealed that the facility had a process of obtaining informed consent prior to the use of restraints including documentation of benefits, potential negative outcome, recommendation and the written acknowledgement of resident representative of the understanding of benefits and negative outcome of restraint use.</p> <p>Observation Resident R22 on July 16, 2024, at 10:37 a.m. revealed that the resident was using hand mitt (a thumbless mitten device is used to restrain a patient's hands) to the left hand.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Clinical record review revealed that Resident R22 was admitted to the facility on [DATE], with the diagnosis of person injured in motor vehicle accident and diffuse brain injury with loss of consciousness.</p> <p>A review of the quarterly Minimum Data Set Assessment (MDS) - a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 14, 2024, revealed Resident 22's BIMS interview (Brief Interview for Mental Status- a tool to assess cognitive function) was not completed; which indicated that the resident was unable to provide or did not provide answers to complete this section).</p> <p>A physician order for Resident R22 dated May 20, 2024, revealed an order for hand mitt to left hand and remove every 2 hours for circulation and skin check for patient safety.</p> <p>Review of clinical record for Resident R22 revealed no evidence that the resident was evaluated of resident's need and use of restraints, including evaluation of the least restrictive measure needed to treat the resident's medical symptom when the facility started using restraint for Resident R22.</p> <p>Further review of clinical record for Resident R22 revealed no evidence that the facility obtained informed consent prior to the use of restraint.</p> <p>Review of progress note for Resident R56 from June 21, 2024 to July 17, 2024 revealed that the facility applied restraint to Resident R56.</p> <p>A physician order for Resident R56 dated June 22, 2024, revealed an order for bilateral soft hand mitt in place at all times to prevent from dislodging tubes and trach. Remove every 2 hours.</p> <p>for range of motion and skin checks.</p> <p>Review of clinical record for Resident R56 revealed no evidence that the resident was evaluated of resident's need and use of restraints, including evaluation of the least restrictive measure needed to treat the resident's medical symptom when the facility started using restraint for Resident R56.</p> <p>Further review of clinical record for Resident R56 revealed no evidence that the facility obtained informed consent prior to the use of restraint.</p> <p>Interview with Director of Nursing on July 17, 2024, at 1:30 p.m. confirmed that the facility did not evaluate Resident R56 and R22 of residents' need and use of restraints, including evaluation of the least restrictive measure needed to treat the resident's medical symptom when the facility started using restraint and obtained documented informed consent prior to the use of restraint.</p> <p>28 Pa. Code 211.8 (c.1)(f) Use of restraints</p> <p>28 Pa. Code 211.12(d) Nursing services</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>41471</p> <p>Based on review of clinical records, facility policies and procedures, interviews with staff, it was determined that the facility failed to conduct a complete and thorough investigation of one alleged violation of unknown source of injury for one of 15 residents reviewed. (Resident R28).</p> <p>Findings include:</p> <p>Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation -, Reporting and Investigating dated, September 2022, revealed, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.</p> <p>Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents.</p> <p>The individual conducting the investigation as a minimum:</p> <ul style="list-style-type: none"> a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors; j. interviews other residents to whom the accused employee provides care or services; k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident R28's wife on July 19, 2024, at 1:10 p.m. stated back in April she saw a bump and a cut with dried blood in the middle of the bump on resident's forehead. She stated resident did not have any brace or hard surface next to the injury when she saw it. She stated she was concerned about the injury and was upset that the facility did not notify her about the injury before she identified.</p> <p>Review of facility investigation dated April 18, 2024, revealed that Resident R48's wife reported to the Life Enrichment Director and Director of Nursing that her husband had a skin tear noted on his forehead. The Director of Nursing immediately assisted the resident back to his room to assess the skin tear. The skin tear was noted to be 4cm long and 0.5cm wide with a red base and pink surrounding area. The resident's wife expressed concern and stated she wanted the resident to be sent to the Emergency Department for evaluation and treatment. The resident's Physician was called to inform of the new skin condition for the resident and gave the order for the resident to be transferred to the ED. The wound care nurse and nurse supervisor also assessed the resident and noted the skin tear above the left eyebrow.</p> <p>Further review of the investigation revealed that an investigation was initiated immediately, and no perpetrator had been identified at that time. Facility interviewed the nurses, nurse aide and respiratory therapist on the hall, Facility also interviewed the staff on the previous day.</p> <p>Review of facility investigation revealed that the facility was not able to identify the exact cause of the injury however concluded that it may have caused from a brace the resident wearing which might not have positioned properly.</p> <p>Investigation also revealed that facility interviewed and obtained statements from the nurse and the nurse aide the night before the injury was reported.</p> <p>Review of statements from Employee E8 Licensed Practical Nurse, who worked on 7:00 p.m. to 7:00 a.m. shift of April 17, 2024, revealed that she did not observe any injury to Resident R28.</p> <p>Review of statements from Employee E9 Nurse Aide, who worked on 7:00 p.m. to 7:00 a.m. shift of April 17, 2024, revealed that she did observe injury to Resident R28 and reported to Employee E10, Licensed Practical Nurse.</p> <p>Review of statements from Employee E10 Licensed Practical Nurse, who worked on 7:00 p.m. to 7:00 a.m. shift of April 17, 2024, revealed that he was notified by the aide to a wound on Resident R28's forehead. He observed that the resident had a dark brown patch on the right side of the forehead. He was not assigned to the resident so he thought the aide would pass the information to resident's nurse.</p> <p>Review of statements from Employee E11 Nurse Aide, who worked on 7:00 a.m. to 7:00 p.m. shift of April 18, 2024, revealed that soon after she provided care to resident R28 she noticed he had a red spot on his head. The area was dry. However, the statement did not reveal any evidence that she reported this to the nurse or the supervisor.</p> <p>Observation of an image of resident's injury with the administrator revealed that the resident had a red colored skin impairment to the forehead with the surrounding area had raised skin, appeared like swelling.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of the investigation revealed that facility did not obtain statements or conducted interviews with other staff who provided care to the resident prior to the injury or other staff who worked on the unit which included respiratory therapists on both shifts.</p> <p>Interview with the Administrator on July 19, 2024, at 2:00 p.m. stated confirmed that the facility investigation did not include statements from other staff who provided care to Resident R28 or other staff who worked on the unit which included respiratory therapists on both shifts,</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(1) 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>41471</p> <p>Based on observations, review of clinical records, facility policies, and interview with staff, it was determined that the facility failed to ensure that a resident with limited range of motion, received appropriate services to prevent further decline in range of motion and maintain appropriate positioning for one of 15 residents reviewed. (Resident R16).</p> <p>Finding Include:</p> <p>Observation of Resident R16 on July 19, 2024, at 1:04 p.m. revealed that the resident was seated in Geri-chair (a large, padded chair that is designed to help seniors with limited mobility). Resident had contractures to upper and lower extremities and resident did not maintain a normal body alignment. Resident was not wearing a splint or brace.</p> <p>Review of care plan for Resident R16 dated April 18, 2015, revealed a care plan which indicated that the resident had contracture with interventions to Bedside passive range of motion to bilateral lower extremity and upper extremity. Resident had ADL self-care deficit related to decline in overall function, decreased activity tolerance.</p> <p>Further review of care plan for Resident R16 dated February 14, 2027, revealed that the resident had contractures of bilateral lower extremity and upper extremity. The care plan interventions included, bedside passive range of motion to Neck, bilateral lower extremity and upper extremity. Left resting hand splint on 4hrs on/off schedule. Bilateral elbow and knee splints for up to 8 hours. Pillow roll to offload right elbow and prevent right elbow from touching right thigh.</p> <p>Review of active physician orders, treatment administration and nurse aide documentation for Resident R16 on July 19, 2024, revealed no evidence that the facility established a splint schedule for Resident R16, or implemented any interventions or services for Resident R16 for head/neck and extremity positioning or prevent further decline in functional range of motion.</p> <p>Interview with Employee E2, Director of Nursing, on July 19, 2024, at 1:04 p.m confirmed that the resident had contracture to the extremities. Employee E2 also confirmed that there was no intervention or services for head/neck positioning, bilateral lower and upper extremities positioning or prevent further decline in functional range of motion.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code: 201.18 (b)(2) Management</p> <p>28 Pa. Code: 211.10 (d) Resident care policies</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>41471</p> <p>Based on observations, reviews of clinical records, facility policies and procedures, and interviews with staff, it was determined that the facility failed to provide adequate treatment and care for intravenous catheter (IV) line in accordance with professional standards of practice for three of three residents reviewed with IV (Resident R6, R51, R28).</p> <p>Findings include:</p> <p>Review of facility policy Peripheral And Midline IV Dressing Changes dated March 2022 revealed that: The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings.</p> <p>Steps in the Procedure</p> <ol style="list-style-type: none"> 1. Assemble equipment. 2. Perform hand antisepsis. 3. Remove old dressing from distal to proximal (towards the head) while placing pressure on the catheter to prevent dislodgement. 4. Clean insertion site with antiseptic solution per protocol. 5. Visually inspect and/or palpate the insertion site as described above. Use sterile gloves if there is a need to touch the insertion site. 6. Allow area to air dry. 7. Apply alcohol-free skin barrier if indicated. Allow to dry before applying the dressing. 8. Do not apply antibiotic ointment to insertion site as part of routine site care. 9. Place new dressing (TSM or gauze) over insertion site. Label dressing with the date and time of dressing change, and initials. <p>Observation of Resident R6 on July 16, 2024, at 10:30 a.m., revealed that the resident had a mid-line intravenous catheter to the left arm. There was no documentation of date on the dressing to indicate the date of insertion or dressing change.</p> <p>Observation of Resident R51 on July 16, 2024, at 10:32 a.m., revealed that the resident had a mid-line intravenous catheter to the left arm. There was no documentation of date on the dressing to indicate the date of insertion or dressing change.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of Resident R28 on July 16, 2024, at 10:48 a.m., revealed that the resident had a intravenous catheter to the right arm. There was no documentation of date on the dressing to indicate the date of insertion or dressing change.</p> <p>Interview and observation with Employee E12, Licensed Practical Nurse on July 16, 2024, at 10:48 a.m., confirmed that IV lines of Resident R6, R51, and R28 did not have dressing date for insertion or dressing change. Employee E12 stated staff should date when inserting IV catheter or when changing the IV dressing.</p> <p>28 Pa. Code: 211.10 (c) Resident care policies</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on review of facility policy, review of clinical record, observation, and staff interview, it was determined that the facility failed to ensure that pain management was provided prior to wound care consistent with professional standards of practice for one of one resident observed (Resident R50).</p> <p>Findings include:</p> <p>Review facility policy on Pain Assessment and Management revealed that under section Purpose: The purpose of this procedure is to help the staff identify pain in the resident and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Under section General Guidelines #1 The pain management program is based on a facility wide commitment to appropriate assessment and treatment of pain based on professional standards of practice, the comprehensive care plan and the resident's choices related to pain management. #2 Pain management is defined as the process of alleviating the residence pain based on his or her clinical condition and established treatment goals. #3 Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain. b. Recognizing the presence of pain c. Identifying the characteristics of pain d. Addressing the underlying causes of pain. e. Developing and implementing approaches to pain management. f. Identifying and using specific strategies for different levels and sources of pain. g. Pain monitoring for the effectiveness of interventions and modifying approaches as necessary. #4. Cognitive, cultural, familial or gender specific influences and the president's ability or willingness to verbalize pain are considered when assessing and treating pain. Comprehensive pain assessments are conducted upon admission to the facility at the quarterly review whenever there is significant change in condition when there is onset of new pain or worsening of existing pain. #5 Acute pain should be assessed 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. Under Steps in the Procedure, Recognizing Pain #1. Observe the resident during rest and movement for physiologic and behavioral (nonverbal) signs of pain. #2. Possible behavioral signs of pain, including a. Negative verbalizations and vocalizations such as groaning, crying, screaming. B. Facial expressions such as grimacing, frowning, clenching of the jaw, etcetera. #4. Ask the resident if he or she is experiencing pain. Be aware that the resident may avoid the term pain. And use other descriptions such as throbbing, aching, hurting, cramping. Numbness or tingling. Under Assessing Pain, #1, assess the resident at admission and during ongoing assessment to help identify the resident who is experiencing pain. #2. Monitor the resident for the presence of pain and the need for further assessment when there is a change of condition. #3 Assess the resident whenever there is a suspicion of new pain or worsening of existing pain. #4 Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level.</p> <p>Review of clinical record revealed that Resident R50 was admitted to the facility on [DATE], with diagnoses of but not limited to Multiple Sclerosis, Quadriplegia (Paralysis involving upper and lower extremities), Encephalopathy Brain disease affecting brain function), Chronic Respiratory Failure, Dysphonia (disorder of the voice), Tracheostomy status (presence of an opening into a person windpipe to allow breathing).</p> <p>Review of Resident R50's physician's orders revealed an order for Wound care:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Montgomery Subacute and Respiratory Center		STREET ADDRESS, CITY, STATE, ZIP CODE 251 Stenton Avenue Plymouth Meeting, PA 19462	
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Cleanse left hip wound with NSS. Apply 1/4 Dakin's-soaked gauze and cover with dry dressing q shift and PRN ordered June 11, 2024.</p> <p>Cleanse right ischium wound with NSS. Apply Dakins soaked gauze and cover with dry dressing daily and PRN ordered June 11, 2024.</p> <p>Cleanse left ischium wound with NSS. Apply Dakins soaked gauze and cover with dry dressing daily and PRN ordered June 11, 2024.</p> <p>Further, physician's order for the following pain medications were in place:</p> <p>Fentanyl Transdermal Patch 72 Hour 25 MCG/HR (Fentanyl) Apply 25 mcg transdermally every 72 hours related to pain, UNSPECIFIED rotate the sites and remove per schedule -Start Date-06/26/2024 Acetaminophen Oral Liquid Give 650 mg via G Tube every 4 hours as needed for pain, UNSPECIFIED -Start Date-04/15/2024.</p> <p>Acetaminophen Oral Liquid Give 650 mg via G Tube every 4 hours as needed for fever temp >101.0 Start Date- 04/15/2024.</p> <p>Dilaudid Oral Tablet 2 MG (Hydromorphone HCl) Give 2 mg via G Tube every 4 hours as needed for Pain UNSPECIFIED Severe Pain 7-10-Start Date-04/26/2024.</p> <p>Hydromorphone HCl Oral Liquid 1 MG/ML Give 2 ml via G Tube every 4 hours as needed for GIVE 2 ML TO EQUAL 2MG related to MUSCLE WASTING AND ATROPHY, NOT ELSEWHERE CLASSIFIED, MULTIPLE SITES (M62.59); PAIN, UNSPECIFIED 2ml/2mg -Start Date-05/21/2024.</p> <p>Review of resident R50's July MAR (medication administration record) revealed that;</p> <p>Resident R50 did not receive Acetaminophen Oral Liquid 650 mg via G Tube every 4 hours as needed for fever temp >101.0,</p> <p>Resident R50 did not receive Acetaminophen Oral Liquid 650 mg via G Tube every 4 hours as needed for pain</p> <p>Resident R50's most recent administration of Hydromorphone HCl Oral Liquid 1 MG/ML (Hydromorphone HCl) Give 2 ml via G Tube every 4 hours as needed for GIVE 2 ML TO EQUAL 2MG related to MUSCLE WASTING AND ATROPHY, NOT ELSEWHERE CLASSIFIED, MULTIPLE SITES (M62.59); PAIN, UNSPECIFIED (R52) 2ml/2mg was on July 18 at 2:52pm.</p> <p>Resident R50 received Dilaudid Oral Tablet 2 MG (Hydromorphone HCl) 2 mg via G Tube every 4 hours as needed for Severe Pain 7-10 on July 3, 2024, at 2:44 pm for pain level of 8 and on July 18 at 11:15 am.</p> <p>Resident R50 received Fentanyl Transdermal Patch 25 MCG/HR (Fentanyl) every 72 hours related to PAIN, with most recent application on July 17, 2024, at 9:56 pm</p> <p>Further review of resident R50's clinical record revealed that there was no prophylactic pain management prior to wound care.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident R50's quarterly MDS (minimum data set- a federally required resident assessment completed at a specific interval) assessment dated [DATE], section B0600 (Speech Clarity) revealed that Resident R50 was coded 2 No Speech, absence of spoken words, section B0700 resident was coded 3 rarely/never understood, section 0800 was coded 3 rarely/never understood.</p> <p>Wound care observations for Resident R50 conducted on July 18, 2024, at 10:50 am with Employee E5 and Employee E6 revealed that Resident R50 had wounds on left and right ischium and left hip.</p> <p>Further observation revealed that Employee E5 prepared the wound supply while Employee E6 was getting Resident R50 ready for the treatment. Employee E6 who was standing on Resident R50's right side of the bed proceeded to turn Resident R50 on his right side (towards Employee E6). Resident R50's left leg was bent at the knee and was positioned over the right leg. Resident R50's who was on his right side, had his head at the level of Employee E6's left hip and slightly turned towards the floor.</p> <p>Further observation revealed that Employee E5, who was standing on the left side of Resident R50 then started to remove the dressing cover from resident R50's wounds (left and right ischium and left hip) at the time Resident R50 did not make any noise and was observed on his right-side facing Employee E6.</p> <p>Further observation revealed that Employee E5 started removing the packing out of Resident R50's wound and at the time Resident R50 started moaning. Further, neither employee E5 nor Employee E6 asked Resident R50 if he was in pain. Further, neither employee was observed observing Resident's facial expression for signs or pain.</p> <p>Interview with Employee E4 and Employee E5 conducted at the time of the observation revealed that resident did not receive pain medication before to the start of the wound treatment. Further interview with Employee E5 confirmed that the Resident R50 was in pain. Further, Employee E4 and Employee E6 continued with the treatment.</p> <p>Review of Resident R50 MAR conducted on July 18, 2024, revealed that Resident R50 received Dilaudid Oral Tablet 2 MG (Hydromorphone HCl) 2 mg via G Tube every 4 hours as needed for Severe Pain 7-10 on July 18 at 11:15 am (after the wound treatment was completed)</p> <p>28 Pa. Code 211.12(d)5 Nursing services</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>41471</p> <p>Based on the review of facility documentation, clinical records, staff and resident interviews, it was determined that the facility failed to provide necessary pharmaceutical services for three of 15 residents reviewed. (Resident R22, R44 and R2)</p> <p>Findings include:</p> <p>Review of facility policy Administering Medications dated April 2019 revealed that</p> <p>Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:</p> <ul style="list-style-type: none"> a. enhancing optimal therapeutic effect of the medication; b. preventing potential medication or food interactions; and c. honoring resident choices and preferences, consistent with his or her care plan. <p>Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).</p> <p>Review of physician orders for Resident R22 revealed an order dated July 12, 2024, for Macrobid oral capsule 100 mg two times a day for urinary tract infection. The medication was originally scheduled to start at 8:00 p.m. on July 12, 2024.</p> <p>Review of Medication Administration Record for Resident R22, revealed that resident did not receive the medication until July 13, 2024, until 1:00 p.m.</p> <p>Review of clinical record revealed that the medication was not available to be administered.</p> <p>Interview with Regional Nurse, Employee E4, on July 19, 2024. At 10:33 a.m. stated the medication was not available to be administered as ordered. Employee E4 stated the medication should have been administered on the same day which was ordered to treat urinary tract infection.</p> <p>Review of physician orders for Resident R44 revealed an order dated July 15, 2024, for Macrobid oral capsule 100 mg two times a day for fever. The medication was originally scheduled to start at 8:00 p.m. on July 15, 2024.</p> <p>Review of Medication Administration Record for Resident R44, revealed that resident did not receive the medication until July 16, 2024, until 9:00 p.m.</p> <p>Review of clinical record revealed that the medication was not available to be administered.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Regional Nurse, Employee E4, on July 19, 2024. At 10:33 a.m. stated the medication was not available to be administered as ordered for Resident R44. Employee E4 stated the medication should have been administered on the same day.</p> <p>Review of a progress note for Resident R2 dated July 15, 2024, revealed that resident was on antibiotic Zosyn intravenously for sputum infection based on culture and sensitivity lab result. Further review of the progress note revealed that outside provider was contacted to insert the intravenous line.</p> <p>Review of progress note dated July 17, 2024, at 12:58 p.m. revealed that the outside provider was successful in placing the intravenous line and medication Zosyn was supposed to start on July 17, 2024. Continued review of the progress note revealed that the medication was not available from the pharmacy.</p> <p>Review of physician orders for Resident R2 revealed an order dated July 15, 2024, for Macrobid oral capsule 100 mg two times a day for fever. The medication was originally scheduled to start at 8:00 p.m. on July 15, 2024.</p> <p>Review of Medication Administration Record for Resident R2, revealed that resident did not receive the medication until July 17, 2024, until 9:00 p.m.</p> <p>Review of clinical record revealed that the medication was not available to be administered.</p> <p>Interview with Regional Nurse, Employee E4, on July 19, 2024. At 10:33 a.m. stated the medication was not available to be administered as ordered for Resident R2. Employee E4 stated the medication should have been administered on the same day.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 211.9(a)(1)(f)(2)(4)(g)(h)(k) Pharmacy 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>41471</p> <p>Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure a response to the consultant pharmacist's recommendation related to the potentially unnecessary medications in a timely manner for two of five residents reviewed. (Resident R63 and Resident R8).</p> <p>Findings include:</p> <p>Review of pharmacy's consultant report for April 15, 2024, revealed a pharmacy consultant recommendation for Resident R23 which stated, Currently receiving hydroxyzine (Atarax) scheduled for prevention of depression. Please note per survey guidelines hydroxyzine is Not appropriate for use as an antidepressant. Consider discontinue now, if appropriate. Further review of the report revealed that the physician agreed and signed to the recommendation and signed on May 7, 2024, with diagnosis changed to pruritis(an irritating sensation that makes you want to scratch). There was no evidence that the facility implemented the recommendation until July 2, 2024</p> <p>Review of pharmacy's consultant report for May 19, 2024, revealed a pharmacy consultant recommendation for Resident R23 which stated, Currently receiving hydroxyzine (Atarax) scheduled for prevention of depression. Please note per survey guidelines hydroxyzine is Not appropriate for use as an antidepressant. Further review of the report revealed that the physician commented and signed to the recommendation and signed on June 12, 2024, with diagnosis changed to anxiety. There was no evidence that the facility implemented the recommendation until June 15, 2024</p> <p>Review of pharmacy's consultant report for June 8, 2024, revealed a pharmacy consultant recommendation for Resident R23 which stated, Currently receiving hydroxyzine (Atarax) scheduled for prevention of depression. Please note per survey guidelines hydroxyzine is Not appropriate for use as an antidepressant. Consider discontinue now, if appropriate. Further review of the report revealed that the physician agreed and signed to the recommendation and signed on July 2, 2024, with diagnosis changed to pruritis (an irritating sensation that makes you want to scratch). There was no evidence that the facility implemented the recommendation until July 2, 2024</p> <p>Review of pharmacy's consultant report for June 8, 2024, revealed a pharmacy consultant recommendation for Resident R51 which stated, Resident is receiving the antipsychotic agent Aripiprazole, but lack an allowable diagnosis to support its use. The following DSM-IV are considered appropriate diagnosis/conditions. The options included affective disorder. Further review of the report revealed that the physician agreed to the recommendation and signed on July 2, 2024.</p> <p>Review of physician order for Resident R51 dated May 23, 2024, revealed an order for Aripiprazole 15 mg once a day for adverse effect of unspecified antipsychotics and neuroleptics. This was not the approved diagnosis per physician recommendations on July 2, 2024 and from the list of approved diagnosis/condition for antipsychotics.</p> <p>(continued on next page)</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>Interview held on July 19, 2024, at 1:11 p.m. with the Director of Nursing, Employee 2 confirmed that the pharmacy consultant recommendations for Resident R51 and Resident R23 was not completed in a timely manner and Resident R51's recommendation of June 8, 2024 was not implemented as approved by the physician.</p> <p>28 Pa. Code 211.9(k)Pharmacy services</p> <p>28 Pa. Code 211.12(d)(3) Nursing services</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>41471</p> <p>Based on a review of clinical records, facility policy, and staff interview, it was determined that the facility failed to ensure that a physician provided a clinical rationale and the duration for the continued use of a PRN (as needed) psychotropic (affecting the mind) medication beyond 14 days for two of four residents reviewed (Resident R57 and R56).</p> <p>Findings include:</p> <p>Facility policy titled Antipsychotic Medication Use (revised 2019), indicated that PRN orders for psychotropic medications are limited to 14 days. If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order.</p> <p>Clinical record review revealed Resident R57 was admitted to the facility June 28, 2024 with a diagnosis that included but not limited to Acute Respiratory Failure with Hypercapnia (inability of lungs to exchange oxygen and high levels of carbon dioxide properly), Cognitive Communication Deficit (communication difficulty caused by a cognitive impairment), and anxiety disorder.</p> <p>Review of Resident R57 medication orders revealed a physician order initiated June 28, 2024 to administer Xanax 0.5 mg (anti-anxiety medication) orally (by mouth) every 8 hours as needed for anxiety. The medication order indicated a stop date of indefinite, which lacked the required stop date within 14 days or a clinical rationale for continuing beyond 14 days.</p> <p>During an interview on June 19, 2024, at 8:56 am, Employee E4, Regional Nurse, confirmed that Resident R57 lacked the required stop date within 14 days and a rationale for continued use beyond 14 days.</p> <p>Review of pharmacy's consultant report for June 24, 2024, revealed a pharmacy consultant recommendation for Resident R56 which stated, Recently admitted on Seroquel (quetiapine) with no clear diagnosis to support current use. Please consider obtaining a psychosocial workup along with performing a medical workup asap to assess for underlying causes of behaviors. Should the workups and nursing behavioral monitoring reveal no significant behaviors . of a chronic psychiatric condition, please consider implementing a tapering schedule and/or discontinue Seroquel.</p> <p>Further review of the report revealed that the physician commented and signed to the recommendation and signed on June 28, 2024, with recommendation for psych consult. There was no evidence that the facility implemented the recommendation to complete a psych consult.</p> <p>Review of physician order for Resident R56 dated June 21, 2024 revealed an order for Seroquel 100 mg at bed time for restlessness and agitation which was not approved diagnosis for Seroquel.</p> <p>28 Pa. Code 211.2 (d)(3)(9) Medical Director.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 211.9 (k) Pharmacy 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Review of clinical records, review of facility policy, observation and staff interview, it was determined that the facility failed to ensure that all drugs and biologicals are stored and labeled in accordance with professional standards for one of three medication carts observed. (Medication carts: McKracken Nursing Unit Front, McKracken Nursing Unit Back and Senton Nursing Unit)</p> <p>Findings include:</p> <p>Review facility policy on administering medications reveal that under Section Policy Statement, medications are administered in a safe and timely manner and as prescribed. Under section Policy and Interpretation and Implementation #2 Director of Nursing Services supervises and directs all personnel who administer medications and or have related functions. #19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aid. It may be kept in the doorway of the residence room with open drawers facing inwards and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the person administering medications, and all outward sides must be inaccessible to residents or others passing by.</p> <p>Review of facility policy on Controlled Substances with most recent revision date of 2022 revealed that under section Policy Statement the facility complies with all laws, regulations and other requirements relating to handling, storage, disposal, and documentation of a controlled medication. Section Policy Interpretation and Implementation revealed that: Handling Controlled Substances #1. Only authorized licensed nursing and or pharmacy personnel have access to Schedule II controlled substances maintained on premises, #2. The Director of Nursing services identify staff members who are authorized to handle controlled substances.</p> <p>Review of Resident R8's clinical record revealed that Resident R8 was admitted to the facility on [DATE] with diagnoses of but not limited to Chronic Respiratory Failure, Hemiplegia/Hemiparesis affecting the right dominant side, Insomnia, Generalized Anxiety Disorder.</p> <p>Review of Resident R8's physician's orders revealed an order for Clonazepam Tablet 0.5 MG *Controlled Drug* Give 0.5 mg by mouth one time a day related to Generalized Anxiety Disorder Hold for sedation with order date of June 22, 2023.</p> <p>Medication Administration observation conducted on July 17, 2024, at 8:41 am with Employee E3 revealed that during medication administration process, Employee E3 was observed removing Clonazepam Tablet 0.5 MG from the medication cart's narcotic box and logged the Clonazepam Tablet 0.5 MG that was removed into the narcotic book.</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>Further observation revealed that Employee E3 crushed the Clonazepam Tablet 0.5 MG together with the other pills. Further, Employee E3 placed the crushed pills (including the crushed Clonazepam Tablet 0.5 MG) on top of the medication cart and went into Resident R8's room which was located two doors away from where the cart was located, went into the room, and left the medication cup containing the crushed medication which also contained the crushed Clonazepam Tablet 0.5 MG unattended.</p> <p>Interview with Employee 8 conducted at the time of the observation revealed that she went into the room to take Resident R3's vital signs. Further Employee E3 also confirmed that she left the crushed Clonazepam Tablet 0.5 MG on the medication cart unattended.</p> <p>28 Pa. Code 2018(b)(l) management</p> <p>28 Pa. Code 211.12(d) Nursing services</p> <p>28 Pa. Code 211.9(i) Pharmacy services</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on observations, interviews with staff, and a review of facility policies and documentation, it was determined that the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <p>The [DATE], policy Food Receiving and Storage states, All food stored in the refrigerator and freezer are covered, dates and labeled. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. Functioning of the refrigeration and food temperatures are monitored daily and at designated intervals throughout the day by the food and nutrition services manager or designee and documented according to state-specific requirements. Refrigerators must have working thermometers and are monitored for temperature according to state-specific guidelines.</p> <p>An initial tour of the Food Service Department was conducted on [DATE], at 9:24 a.m. with Employee E13, Food Service Director (FSD), which revealed the following:</p> <p>The facility staff was washing dishes using hot water dish machine. The label on the dish machine read the required temperature for washing cycle as Wash-150 and Rinse 180.</p> <p>The temperature read at the time of washing the dish at 9:43 a.m. as wash 140 and rinse 130. The temperature did not go up to the required temperature during the process. It was observed that the employee removed dishes from the dish washer and took it back to the kitchen to storage. During the observation surveyor asked if the dishes were washed and clean and the employee said yes</p> <p>Interview with Employee E13 on [DATE], at 9:50 p.m. stated the dishes are not clean and disinfected if the required temperature was not met.</p> <p>Observation of the refrigerator with Employee E13 revealed that there were expired beats, expired cranberry sauce and bags of bread, bagels and burger bun with no expiration date or open date. Employee E13 stated the above food items should be discarded.</p> <p>Observation inside the kitchen revealed that there was ice machine inside the kitchen. A cleaning log was displayed above the kitchen with monthly cleaning schedule. Further observation revealed that the last ice machine cleaning was completed in May and the June and cleaning was documented as completed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395847	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/19/2024
NAME OF PROVIDER OR SUPPLIER Montgomery Subacute and Respiratory Center		STREET ADDRESS, CITY, STATE, ZIP CODE 251 Stenton Avenue Plymouth Meeting, PA 19462	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations of resident room [ROOM NUMBER] revealed that there was a refrigerator inside resident's room. It was observed that there was left over food and other food items in the refrigerator without any labelling. There was no documentation available at the location for temperature monitoring. It was observed that the resident in the room, Resident R18, had a tracheostomy (a permanent or temporary opening in the neck that's surgically created to provide an alternative airway for breathing) tube and had a BIMS(Brief Interview for Mental Status- a tool to assess cognitive function) score of 11 which indicated that the resident's cognitive ability was moderately impaired.</p> <p>Interview with the FSD at 12:00 p.m. on [DATE], confirmed the there was no temperature monitoring for the refrigerator in resident room [ROOM NUMBER] and it was the staff's responsibility to clean, date and monitor the refrigerator.</p> <p>28 PA Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46508</p> <p>Based on review of facility policy, resident's clinical record, observation, and staff interview, it was determined that the facility failed to ensure that proper infection control procedures was followed during medication administration for two of four residents observed (Resident R8 and Resident R41).</p> <p>Findings:</p> <p>Review facility policy on Administering Medications reveal that under Section Policy Statement, medications are administered in a safe and timely manner and as prescribed. Under section Policy and Interpretation and Implementation: #25 revealed that staff follows established facility infection control procedures. Examples: hand washing, antiseptic technique, gloves, isolation precautions etcetera for the administration of medications as applicable.</p> <p>Review facility policy on Hand Washing/Hand Hygiene, revealed that under a section Policy Statement, this facility considers hand hygiene the primary means to prevent the spread of health associated infection. Under section Policy Interpretation and Implementation, Administrative Practices to Promote Hand Hygiene #1 All personnel are trained and regularly in serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infection. #2 All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Under Indications for Hand Hygiene #1 hand hygiene is indicated for #a. Immediately before touching a resident. #b. Before performing an aseptic task. #d. After touching a resident. #e. After touching the resident's environment. #f. Before moving from work on a soil body site to a clean body site on the same resident and #g. Immediately after glove removal.</p> <p>Medication Administration observation conducted on July 17, 2024, at 8:41am with Employee E3 revealed that during medication administration, Employee E3 was observed administering Fluticasone nasal spray to Resident R8.</p> <p>Further observation revealed that Employee E3 inserted the nasal applicator/nozzle of the Fluticasone nasal spray into resident R8's right nostrils, sprayed the Fluticasone nasal spray into the Resident R8's right nostrils. Further, Employee E3 then proceeded to remove the nasal applicator/nozzle of the Fluticasone nasal spray from Resident R8's right nostrils and proceeded to insert it into Resident R8's left nostrils without disinfecting, sanitizing, or wiping the nasal applicator/nozzle. Employee E3 then proceeded to spray the Fluticasone nasal spray into resident R8's right nostrils, withdraw the nasal applicator/nozzle out and proceeded to replace the Fluticasone nasal spray back into its box.</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 - Few</p>	<p>Further observation revealed that during medication administration for Resident R41, Employee E3 did not wash/sanitize her hands before putting on gloves. Employee E3 then proceeded to go to Resident R41's room and placed the medications on top of the overhead table. Employee E3 then proceeded to check the Resident R41's heat rate by auscultating (listening to using a stethoscope) Resident R41's chest. After auscultating Resident R41's chest, Employee E3 proceeded to check Resident R41's PEG placement by removing resident R41's gown and auscultation Resident R41's abdomen. Employee E3 then proceeded to administer Resident R41's, medication without washing, sanitizing her hands, or changing her gloves. Further, Employee E3 then proceeded to administer Resident R41's artificial tears eye drops with the same gloves. Resident R41 refused the artificial tears eye drop.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code(d)(1)(5) Nursing services</p>		