

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER Gardens at Millville, The		STREET ADDRESS, CITY, STATE, ZIP CODE 48 Haven Lane Millville, PA 17846	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</p> <p>Based on observation, review of select facility policy and clinical records and staff and resident interview, it was determined that the facility failed to determine a resident's capability to self-administer medication for one of 16 residents reviewed (Resident B1).</p> <p>Findings include:</p> <p>A review of facility policy titled Administering Medications, provided by the facility on May 21, 2024, indicated it is the policy that medications shall be administered to in a safe and timely manner, and as prescribed. Residents may self-administer their own medications only if the attending physician, in conjunction with the Interdisciplinary Team (IDT) had determined that they have the decision-making capacity to do so safely.</p> <p>A review of the facility policy titled Self-Administration of Medications, provided by the facility on May 21, 2024, indicated it is the policy to promote the right of the resident to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe. The staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. Self-administered medications must be stored in a safe a secure place in the resident's room and if not, then the medications will be stored on a central medication cart or in the med room. Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party.</p> <p>Review of Resident B1's clinical record revealed admission to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease (COPD-lung disease that blocks airflow and makes it difficult to breathe) and pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and in the heart). The resident was assessed as cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status - a tool to assess cognitive function - a score of 13-15 indicates cognitively intact).</p> <p>A physician's order dated August 31, 2023, was noted for Combivent Respimat Inhalation (inhaled medication used to treat chronic obstructive pulmonary disease) Aerosol Solution 20-100 MCG/ACT: one puff orally every 4 hours as needed for SOB (shortness of breath). The physician's order was discontinued on September 20, 2023.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation and interview with Resident B1 in his room on May 21, 2024, at 11:00 AM, the resident pulled from his left pant pocket an inhaler and stated that this helps me breathe. I use it one or two times a day, but no more than three times. Observation revealed the resident was holding an inhaler labeled Combivent Respimat. During the interview, the resident stated that nursing gave him the inhaler awhile ago.</p> <p>A second observation of Resident B1 on May 21, 2024, at 1:30 PM, in the presence of Employee 1, LPN (licensed practical nurse) revealed that the resident continued to have the inhaler in his pant pocket.</p> <p>During an interview on May 21, 2024, at approximately 1:35 PM, with Employee 1, she confirmed that the resident's clinical record contained no current physician order for Resident B1 to continue to use, and self-administer the Combivent Respimat inhaler, no self-administration assessment of the resident's ability to self-administer, and no care plan indicating that the resident does self-administer the product. Employee 1 further confirmed that the physician's order for the resident's use of the Combivent Respimat inhaler was discontinued on September 20, 2023, but that the inhaler remained in the resident's possession for the resident's use.</p> <p>28 Pa. Code: 211.9(a)(1)(k) Pharmacy services.</p> <p>28 Pa Code 211.10 (c)(d) Resident care policies</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing services</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** 26142</p> <p>Based on observations and staff interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a clean and comfortable environment for residents.</p> <p>Findings include:</p> <p>Observations of resident room [ROOM NUMBER] during an environmental tour of the facility on May 21, 2024, at 10 AM revealed the floor surrounding and beneath the resident's bed was littered with dirt, paper debris and a brown sticky substance.</p> <p>Observation of resident room [ROOM NUMBER] D, revealed a large amount of dirt, paper debris and a brown sticky substance on the floor, under the bed and around the bedside table.</p> <p>The hot water temperature in the 200 hallway resident shower room on May 21, 2024 at 10 AM was 100 degrees Fahrenheit. The hot water temperatures in the locked dementia care unit shower room was only 98 degrees Fahrenheit.</p> <p>The hot water temperatures in the 100 hallway shower rooms May 21, 2024, at 10 A.M. ranged from 90 degrees and 98 degrees Fahrenheit.</p> <p>The facility failed to maintain water temperatures that were sufficiently warm enough for the comfort of residents during bathing/showering.</p> <p>Interview with the Administrator on May 21, 2024, at approximately 2 PM confirmed that the resident environment was to be maintained in a clean manner and comfortable hot water temperatures are to be maintained for the residents' comfort.</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on a review of clinical records, select facility policy and investigative reports and staff and resident interviews it was determined that the facility failed to consistently implement sufficient measures to protect a resident (Resident A3) out of 16 sampled from sexual verbal abuse perpetrated by another resident (Resident A2).</p> <p>Findings included:</p> <p>A review of a facility policy for Abuse last reviewed by the facility on June 21, 2023, indicated that residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of property. Residents must not be subjected to abuse by anyone including but not limited to facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians friends or other individuals.</p> <p>Clinical record review revealed that Resident A2 was admitted to the facility on [DATE], with diagnosis to include dementia, alcohol abuse with unspecified alcohol induced disorder, dementia, nicotine dependence and diabetes.</p> <p>A review of a quarterly Minimum Data Set assessment (MDS, is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes) dated February 13, 2024, revealed Resident A1 was moderately cognitively impaired with a BIMS score of 9 (BIMS a test administered to all residents in skilled nursing facilities to assess patient cognitive patterns, behavior, and mood, a score of 8-12 suggests moderate cognitive impairment) and required minimal staff assistance with activities of daily living and independently ambulates.</p> <p>A review of the resident's care plan revealed that Resident A2 The resident has an alteration in neurological status related to Dementia, the resident is verbally aggressive with staff, sexual behaviors, touching female resident and exposing his penis to a resident</p> <p>Interventions to include:</p> <ul style="list-style-type: none"> - 1:1 supervision of staff when out of his room - Frequent visual checks as needed -resident door alarm <p>Nursing documentation and the residents care plan indicated that he had a history of exhibiting incidents of inappropriate sexual behaviors in the facility.</p> <p>Clinical record review revealed that Resident A3 was admitted to the facility on [DATE] with diagnosis to include dementia.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Quarterly MDS dated [DATE] revealed her to be moderately, cognitively impaired with a BIMS score of 9. and she required staff assistance with activities of daily living.</p> <p>Her current care plan did not include any mention of sexually inappropriate behaviors.</p> <p>Nursing documentation and a facility event investigation dated December 29, 2023 at 11:45 A.M., a nurse aide entered the East TV lounge and found Resident A2 seated on a chair in the front corner of the room with the front of his pants pulled down and Resident A3, seated directly in front of him in her wheelchair, had her hands on his genitals. Resident A2 immediately pulled up his pants and moved her hands away from him when the nurse aide entered the room. The residents were immediately separated and Resident A2 was laced on 1 to 1 supervision. A motion sensor alarm was placed in the residents entry door to alert staff when the resident leaves room.</p> <p>Nursing documentation dated February 19, 2024 at 6:20 P.M. revealed, resident noted to continue to shut off motion sensor alarm. Alarm was moved out of residents reach by door but still in place it would sound upon exiting. Resident was being walked to smoke with NA following, resident again stated to NA you are a fat slob, why are you following me, you need to lose weight.NA informed resident she was obligated to walk with resident for safety, resident stated I don't want you to follow me, suck my dick. NA ignored residents words and continued to walk with resident a safe distance.</p> <p>An Interdisciplinary Note dated February 20, 2024 at 08:42 A.M. revealed, ID Team met to discuss and review recent behaviors and appropriate interventions for resident safety as well as a safety of other residents on unit. Resident A2 noted to be disabling motion detector and going under the alarming stop sign thus defeating the purposefully these interventions.</p> <p>Staff placed a clip alarm on outside of the doorway which will activate upon opening of door as well as the motion sensor placed at the bottom of the resident door.</p> <p>A nurses note dated April 14, 2024 at 3:30 revealed, Resident A2 was observed by staff standing in his doorway, with his pants around his thighs and his penis and groin exposed. Female Resident A3 was observed touching his penis. Resident noted to be standing in his doorway just inside of where wireless door alarm is located, therefore wireless alarm did not sound at time of incident. When resident interviewed resident began cursing and yelling at staff,stating Fuck you, resident telling staff members to suck his dick. Staff went to separate residents immediately; Female resident removed from hallway and relocated to TV lounge with staff. Resident A2 became agitated and verbally aggressive towards staff, when staff intervened, Resident approached staff members in aggressive manner, screaming in their facesFuck you, Go fuck yourself, and making nonsensical sounds, while sticking his tongue out and thrusting his pelvis towards staff. Resident observed lifting his cane up and threatening to hit staff members. Redirection provided, resident grabbed himself, and told staff to suck his dick. After much encouragement RN supervisor was able to redirect resident to his room.</p> <p>The noted intervention implemented at the time of the incident was to add a motion sensor to his bed. The resident was observed by staff to turn off the alarm. Staff then moved the alarm to the middle of the underside of the bed out of his reach.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview May 21, 2024 at 3 P.M., the DON stated that on April 14, 2024, the date of the incident, purposefully stepped back from the doorway (the bottom of the doorway where the motion sensor alarm was located. Resident A3 was standing outside the doorway, feet away from the motion sensor. She reached across the middle portion of the doorway, out of the sensor detecton area and was noted to be touching Resident A2 inappropriately.) at Resident A2's direction. She confirmed that the door motion detectors were an ineffective intervention for this resident with repeated inappropriate sexual contact with female residents.</p> <p>The DON further confirmed that the facility was aware of Resident A2's aggressive and sexual behaviors and failed to demonstrate that Resident A3 was free from abuse perpetrated by Resident A2.</p> <p>28 Pa. Code 201.29 (a)(c) Resident rights</p> <p>28 Pa. Code 211.12 (d)(1)(3) Nursing services</p> <p>28 Pa. Code 201.18 (e)(1) Management</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>26142</p> <p>Based on observation and staff interview, it was determined that the facility failed to maintain an environment free from accident hazards on one of two resident hallways.</p> <p>Findings include:</p> <p>Observations of the east hallway May 21, 2024 at 9 AM, 11 AM. and again at 1 PM on the upper end of the 100 hallway revealed 7 wheelchairs. a straight back chair, a large linen cart, dirty linen carts, a trash bin and a wheelchair charger plugged into a hallway outlet lining the left side of the hallway, obstructing access to the handrails on the wall on that side of the corridor.</p> <p>Observations of the east hallway, May 21, 2024, at 9:10 AM and again at 1:10 PM on the lower end of the 100 hallway revealed 5 wheelchairs, a large linen cart, trash container and a double dirty linen cart, lining the left side of the hallway, obstructing access to the handrails on the wall on that side of the corridor.</p> <p>Residents were observed to be out and about on the unit at those times, self-propelling in wheelchairs and/or ambulating with walkers.</p> <p>During an interview May 21, 2024 at 2 P.M., the Nursing Home Administrator confirmed that the hallway handrails should not be obstructed and residents should have unimpeded access to the handrails in the corridor.</p> <p>28 Pa. Code 201.18 (e)(2.1) 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on observations and staff interview, it was determined that the facility failed to maintain infection control practices to prevent the spread of infection including for one of 16 sampled residents (Resident A1).</p> <p>Findings include:</p> <p>Observations on May 21, 2024 at 9 AM, 11 AM and 1 PM revealed Resident A1 was his bed, and upon each observation his urinary foley catheter collection bag was observed directly on the floor. The collection bag was not in a privacy bag at the time of these observations.</p> <p>There were multiple uncovered, clean dressings, a opened box of clean dressings an open tube of Hydrocortisone cream (with the cap off), an open tube of Triamcinolone (a topical steroid cream) with the cap off and an open bottle of sodium chloride solution (used for irrigation) with no open date on the bedside table in Resident A1's room. On top of these resident care and treatment supplies was an uncovered, clean incontinence brief.</p> <p>On the resident's dresser was a wash basin containing multiple used hand towels, both sealed and unsealed dressings, gloves and dressing tape.</p> <p>In resident room [ROOM NUMBER] D, there was an uncapped, open plastic gallon container of distilled water (used for humidification in the resident's oxygen concentrator) on the resident's dresser.</p> <p>During an interview May 21, 2024 at 2 PM, the Director of Nursing confirmed that resident care equipment and supplies should be maintained in a sanitary manner.</p> <p>28 Pa Code 211.12 (d)(5) Nursing Services</p>