

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395876	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2024
NAME OF PROVIDER OR SUPPLIER  Cumberland Crossings Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE  1 Longsdorf Way Carlisle, PA 17013	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>33879</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure the resident assessment accurately reflected the resident status for three of 16 residents reviewed (Residents 30, 40, and 44).</p> <p>Findings Include:</p> <p>Review of Resident 30's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and chronic kidney disease, stage 4 (CKD-a condition in which the kidneys are damaged and can't filter blood as well as they should).</p> <p>Review of Resident 30's current physician orders revealed an order, dated April 20, 2024, for a 16 French (indicates the size of the catheter) catheter (tube inserted into the bladder to drain urine).</p> <p>Review of Resident 30's admission MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental, or psychosocial needs), dated April 26, 2024, revealed in Section H, Resident 30 was coded as having an indwelling urinary catheter.</p> <p>Further review of Section H revealed that Resident 30's urinary continence was coded as occasionally incontinent and bowel continence was coded as not rated.</p> <p>During an interview with the Nursing Home Administrator (NHA) on May 16, 2024, at 9:32 AM, he confirmed that Resident 30's bowel and bladder continence was incorrectly coded on the MDS.</p> <p>Review of Resident 40's clinical record revealed diagnoses including type 2 diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment) and peripheral vascular disease (condition that results in decreased blood flow to the extremities of the body).</p> <p>Review of Resident 40's physician orders revealed an order for methenamine Hippurate (antibiotic medication used to stop the growth of bacteria in urine) 1 gram twice a day for the indication of history of urinary tract infections. Review of the order revealed it had been started on September 28, 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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 40's Quarterly Minimum Data Set (MDS - standardized assessment tool utilized to identify a resident's physical, mental, and psychosocial needs), with an assessment reference date of April 9, 2024, revealed that Section N - Medications, subsection N0415 High-Risk Drug Classes: Use and Indication, subsection F - Antibiotic was assessed to reflect that Resident 40 was not receiving an antibacterial medication.</p> <p>During a staff interview on May 16, 2024, at approximately 10:15 AM, Nursing Home Administrator confirmed that the MDS was coded incorrectly and that Resident 40's Quarterly MDS should have included the use of an antibacterial medication.</p> <p>Review of Resident 44's clinical record revealed diagnoses that included chronic kidney disease, hypertension and diabetes mellitus (a metabolic disorder in which the body has high sugar levels for prolonged periods of time).</p> <p>Review of Resident 44's Quarterly MDS with ARD (assessment reference date last day of the assessment period) of November 8, 2023, revealed, under Section N- Medications subsection N0350. Insulin, Resident 44 was coded as receiving insulin injections over the past seven days.</p> <p>Review of Resident 44's State Optional MDS with ARD of November 8, 2023, revealed, under Section N- Medications subsection N0350. Insulin, Resident 44 was coded as receiving insulin injections over the past seven days.</p> <p>Review of Resident 44's Modification of Quarterly MDS with ARD of November 8, 2023, revealed, under Section N- Medications subsection N0350. Insulin, Resident 44 was coded as receiving insulin injections over the past seven days.</p> <p>Review of Resident 44's Quarterly MDS with ARD of February 7, 2024, revealed, under Section N- Medications subsection N0350. Insulin, Resident 44 was coded as receiving insulin injections over the past seven days.</p> <p>Review of Resident 44's State Optional MDS with ARD of February 7, 2024, revealed, under Section N- Medications subsection N0350. Insulin, Resident 44 was coded as receiving insulin injections over the past seven days.</p> <p>During an interview with Employee 1 (Registered Nurse Assessment Coordinator) on May 15, 2024, at 11:04 AM, she revealed the MDS was likely marked for insulin as resident was on Victoza which is a hypoglycemic injection, but she confirmed it is not insulin and the MDS assessments were not correct.</p> <p>During an interview with the NHA on May 15, 2024, at 1:07 PM, he revealed he would expect Resident 44's MDS assessments to be coded accurately.</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>33879</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure the resident comprehensive plan of care was reviewed and revised in accordance with residents' needs for two of 12 residents reviewed (Residents 40 and 45).</p> <p>Findings include:</p> <p>Review of Resident 40's clinical record revealed diagnoses including type 2 diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment) and peripheral vascular disease (condition that results in decreased blood flow to the extremities of the body).</p> <p>Review of Resident 40's consultant wound evaluation, dated April 29, 2024, revealed Resident 40 developed two venous wounds (wound caused by insufficient blood circulation) on the lower portion of the right leg. One was described as a full thickness wound measuring 4 centimeters (cm - metric unit of measure) in length by 4 cm width with 0.1 cm of depth; the second measured 0.5 cm length by 1.5 cm width with 0.1 cm of depth. Treatment was recommended by the consultant wound team and accepted by the attending physician. Review of the most recent consultative wound assessment revealed that on May 13, 2024, Resident 40 continued to suffer from venous wounds of the lower right leg.</p> <p>Review of Resident 40's comprehensive plan of care on May 14, 2024, revealed Resident 40's comprehensive plan of care did not include a care plan with a focus, goals, or interventions for the venous wounds of the lower right leg.</p> <p>During a staff interview on May 16, 2024, at approximately 10:15 AM, Director of Nursing revealed that Resident 40's comprehensive plan of care should have included the wounds suffered on the right lower leg of Resident 40.</p> <p>Review of Resident 45's clinical record revealed diagnoses that included: bronchopneumonia (pneumonia that affects the alveoli which are tiny air sacs inside the lungs), cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced), and muscle weakness.</p> <p>Review of Resident 45's care plan on May 14, 2024, revealed a focus area: The resident has oxygen therapy related to aspiration pneumonia (infection of the lungs caused by inhaling saliva, food, liquid, vomit, or even small foreign objects), with an intervention for five liters of oxygen, initiated on January 29, 2024.</p> <p>Review of Resident 45's physician orders revealed an order for five liters of oxygen that was discontinued on March 12, 2024.</p> <p>Further review of Resident 45's physician orders revealed he was ordered oxygen as needed with a start date of March 12, 2024, that was discontinued on April 11, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>37013</p> <p>Based on observations, facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide appropriate urinary catheter care for one of two residents reviewed for catheters (Resident 30).</p> <p>Findings Include:</p> <p>Review of facility policy titled Orders for Indwelling Urinary Catheters [tubing inserted into the bladder to drain urine into a bag] and Catheter Care, revised September 2017, revealed Residents/patients with indwelling urinary catheters will have appropriate care and monitoring.</p> <p>Review of Resident 30's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and chronic kidney disease, stage 4 (CKD-a condition in which the kidneys are damaged and can't filter blood as well as they should).</p> <p>Review of Resident 30's current physician orders revealed an order, dated April 20, 2024, for a 16 French (indicates the size of the catheter) catheter.</p> <p>Observations of Resident 30 on May 14, 2024, at 9:45 AM, 10:11 AM and 11:06 AM, revealed Resident 30 in bed, asleep, with her catheter bag laying on the floor beside her bed.</p> <p>During an interview with the Director of Nursing on May 16, 2024, at 9:31 AM, she stated that Resident 30's catheter bag should not have been on the floor.</p> <p>28 Pa code 211.12(d)(1)(2)(5) Nursing services</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>48484</p> <p>Based on facility policy review, record review, and resident and staff interviews, it was determined that the facility failed to ensure proper monitoring for maintenance of acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance for one of three residents reviewed for nutrition (Resident 44).</p> <p>Findings include:</p> <p>Review of facility policy titled Weight Assessment and Intervention revised September 2008, read, in part, Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. The Dietitian will respond within 72 hours of receipt of written notification.</p> <p>During an interview with Resident 44 on March 14, 2024, at 9:46 AM, she revealed she has lost weight at the facility when she was sick, and she has stomach issues and is a picky eater.</p> <p>Review of Resident 44's weight, revealed a significant weight loss of 5.3% from March 23, 2024, to March 24, 2024, confirmed by a re-weigh measure taken on March 25, 2024.</p> <p>Review of Resident 44's clinical record revealed she was covid positive at the time of the weight loss.</p> <p>Review of Resident 44's nursing progress notes revealed a note on March 24, 2024, at 1:50 PM, that read, in part, Resident covid positive .Resident continues with nausea and lack of appetite. Ginger ale and as needed Tums with moderate effect. Fluids encouraged.</p> <p>Further review of Resident 44's nursing progress notes revealed a note on March 26, 2024, at 1:45 PM, that read, in part, Resident continues on isolation for positive covid. Complaints of nausea, as needed tums given with little effectiveness.</p> <p>Review of Resident 44's clinical record revealed a nurse practitioner note on April 3, 2024, that read, in part, Chief Complaint: Nausea, loose stools, abdominal pain .She continues with nausea and poor appetite. She feels weak. She does report abdominal pain .Start peripheral IV and start [IV fluids]</p> <p>During an interview with Employee 2 (Registered Dietitian) on May 15, 2024, at 12:33 PM, she revealed she was not notified by nursing of the significant weight loss per the facility policy, and that's why she did not see it or assess Resident 44 until she discovered the weight loss on April 15, 2024; she further revealed she would have assessed Resident 44 within 72 hours following the weight loss and would have implemented interventions at the time based on the resident's preference.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing on May 16, 2024, at 10:21 AM, she revealed there are reports the Dietitian can run to evaluate residents for significant weight loss and that it should be a team effort rather than reliance on nursing staff for notification of significant weight changes; she further revealed that she would expect nutrition assessments to be conducted timely in response to significant weight changes per the facility policy.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa Code 211.12(d)(1)(3)(5) Nursing Services.</p>		