

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395896	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Homewood at Martinsburg PA Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 437 Givler Drive Martinsburg, PA 16662	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>42079</p> <p>Based on review of facility policy and clinical records, as well as interviews with staff, it was determined that the facility failed to develop individualized care plans for two of 44 residents reviewed (Residents 28, 105).</p> <p>Findings include:</p> <p>A facility policy for Comprehensive, person-Centered Care Plans, dated January 10, 2024, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the resident and resident's condition change.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 28, dated August 15, 2024, revealed that the resident was rarely/never understood, could rarely/never understand, was cognitively impaired, required assistance with care needs, and had diagnoses that included heart failure and dementia.</p> <p>Observations of Resident 28 on November 18, 2024, at 11:26 a.m. revealed that the resident was asleep in bed. He had intravenous access in his right forearm.</p> <p>A nursing note for Resident 28, dated November 20, 2024, at 9:05 p.m. revealed that Resident 28's midline (an intravenous catheter used to administer medications or fluids for up to 30 days) had good blood return and flushed well. There were no signs of midline complications. The dressing was clean, dry and intact. Dextrose five percent (fluid injected into a vein through an IV to replace lost fluids and provide carbohydrates to the body) was running at 75 milliliters per hour.</p> <p>Resident 28's current care plan did not include any information or interventions related to the resident's care needs for the use of a midline catheter.</p> <p>Interview with the Director of Nursing on November 21, 2024, at 2:18 p.m. confirmed that there was no information in Resident 28's care plan related to the care and use of his midline catheter.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note for Resident 105, dated November 12, 2024, at 11:44 a.m. revealed that the resident had two seizure episodes in the therapy gym. The physician was notified and gave an order to send the resident to the hospital, and he was admitted with a diagnosis of seizure. After treatment he was discharged from the hospital on November 15, 2024, with a diagnosis of epilepsy (a chronic brain disease that causes seizures).</p> <p>Resident 105's current care plan did not include any information or interventions related to the resident's care needs for a seizure disorder.</p> <p>Interviews with the Director of Nursing on November 18, 2024, at 1:19 p.m. confirmed that there was no information in Resident 105's care plan related to his seizure disorder.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy.</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>48941</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for one of 44 residents reviewed (Resident 25).</p> <p>Findings include:</p> <p>A facility policy for Comprehensive Person-Centered Care Plans, dated January 10, 2024, included that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the resident and resident's condition change.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 25, dated October 15, 2024, indicated that the resident was cognitively impaired, was understood and able to understand others, required assistance with care needs, received a diuretic (a medication used to treat fluid build-up), received oxygen, and had diagnoses that included respiratory failure (blood does not have enough oxygen and causes difficulty breathing) and hypertension (high blood pressure).</p> <p>Current physician's orders for Resident 25 included an order for the resident to receive 40 milligrams (mg) of Furosemide (a diuretic medication) daily for hypertension and cerebrovascular disease (conditions that affect blood flow to your brain). A review of Resident 25's Medication Administration Record (MAR) for September, October, and November 2024 revealed that the resident received Furosemide as ordered; however, there was no documented evidence that the resident's care plan was revised to reflect her need for diuretic medication.</p> <p>Interview with the Director of Nursing on November 21, 2024, at 11:02 a.m. confirmed that there was no documented evidence that Resident 25's care plan was revised to reflect her need for diuretic medication and it should have been.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>42079</p> <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure medications were administered correctly for one of 44 residents reviewed (Resident 89). This deficiency was cited as past non-compliance.</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 89, dated September 4, 2024, revealed that the resident was understood, could understand, was cognitively impaired, required assistance with care needs, and had diagnoses that included renal failure and dementia.</p> <p>A nursing note for Resident 89, dated October 21, 2024, at 10:15 p.m., revealed that Resident 89 was given another resident's medication. The staff member became distracted and accidentally gave the medication to the wrong resident. A nursing note for Resident 89, dated October 21, 2024, at 10:18 p.m., revealed that Resident 89 was sent to the emergency room for further evaluation and treatment to monitor for any possible drug interactions.</p> <p>The medications that Resident 89 received included 650 milligrams of Tylenol (pain reliever), 5 mg of Zyprexa (antipsychotic medication), 200 mg of Atorvastatin (cholesterol lowering medication), 40 mg of Famotidine, 750 mg of Levetiracetam (anticonvulsant), 300 mg of Lithium (psychotropic medication), 200 mg of Hydroxychloroquine (antimalarial), and 75 mg of Effexor (Serotonin and norepinephrine reuptake inhibitors).</p> <p>Interview with the Director of Nursing on November 19, 2024, at 11:03 a.m. confirmed Resident 89 received the wrong medication and was sent to the hospital for evaluation.</p> <p>A system change was implemented that included a review of the resident impacted, other residents that could be impacted by medication errors, training for all licensed staff about the five rights of medication, and audits of medication passes.</p> <p>A plan was developed on October 22, 2024, for random audits to be conducted</p> <p>The results of the audits were to be discussed during the monthly QA meeting.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38012</p> <p>Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that the environment remained as free of accident hazards as possible for two of 44 residents reviewed (Residents 25, 45).</p> <p>Findings include:</p> <p>Observations in the main dining room on November 18, 2024, at 11:26 a.m. revealed that there was a hot plate in use to keep coffee pots warm. The hot plate was sitting on the counter at waist height and was accessible by the residents. At 11:26 a.m. Resident 3 was observed pouring a cup of hot water and making hot chocolate at the counter where the hot plate was located.</p> <p>Interview with Resident 3 on November 18, 2024, at 1:06 p.m. revealed that she did get her own hot water today; however, she has not done that before. She stated that staff always get the hot water or coffee for them, and she is not sure why she did it herself today.</p> <p>Interview with Family Member 1 on November 18, 2024, at 12:08 p.m. revealed that she eats lunch with her family member everyday in the dining room. She stated that she has never seen any residents approach the coffee, hot water, or hot plate and that staff always get the residents their coffee and hot water.</p> <p>Interview with Dietary Aide 2 revealed that the residents do not get themselves coffee, the staff always do, but that the hot plate is within the residents' reach.</p> <p>Interview with the Director of Nursing on November 18, 2024, at 3:25 p.m. revealed that she was not aware there was a hot plate in the dining room that was within the residents' reach. She stated that it would be removed immediately.</p> <p>A facility policy for wheelchairs, dated January 10, 2024, indicated that it was the policy of the facility to provide transportation with safety and comfort and that residents transported in a wheelchair by staff should have their leg rests on and feet on the foot pedals.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 25, dated October 15, 2024, indicated that the resident was cognitively impaired, was understood and able to understand others, required assistance with care needs, used a wheelchair, was dependent on staff for mobility in her wheelchair, and had a diagnosis of dementia.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations of Resident 25 on November 18, 2024, at 11:17 a.m. revealed that the resident was transported in her wheelchair down the hallway from her room to the dining room by Nurse Aide 3. The wheelchair had no leg rests on it to prevent the resident from dragging her feet. Nurse Aide 4 was observed walking with Nurse Aide 3 as she transported Resident 25 to the dining room. An interview with Nurse Aide 4 at that time revealed that she did not see the leg rests in the resident's room and did not believe the resident had leg rests for her chair. Nurse Aide 4 went to the resident's room and found a set of leg rests and put them on her wheelchair. Nurse Aide 4 and Nurse Aide 3 confirmed that they should not have transported the resident in her wheelchair without leg rests.</p> <p>Interview with the Director of Nursing on November 19, 2024, at 11:02 a.m. confirmed that leg rests should have been used when transporting Resident 25 in her wheelchair.</p> <p>Facility policy for the safe lifting and moving of residents, dated January 10, 2024, indicated that manual lifting of residents should be eliminated when feasible and that staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts) and mechanical lifting devices.</p> <p>An annual MDS for Resident 45, dated October 23, 2024, indicated that the resident had moderate cognitive impairment, required partial to moderate assistance from staff for moving from sitting to standing position, and had diagnoses that included dementia.</p> <p>Observations of Resident 45 on November 18, 2024, at 11:02 a.m. revealed the resident was lying in her bed ringing her call bell to go to the bathroom. Registered Nurse 1 entered the room and assisted the resident to sit on the edge of her bed so she could walk to the bathroom in her room. While Resident 45 was sitting on the edge of the bed, Registered Nurse 1 leaned forward and placed her arm under the resident's right arm attempting to assist the resident to a standing position. The resident was unable to stand upright, and Registered Nurse 1 again placed her arm under the right arm of Resident 45 and helped to pull her to a standing position. The resident was walked to the bathroom and care was provided. The resident was again assisted to the standing position from the toilet with the support of Registered Nurse 1 pulling under the resident's left arm. No gait/transfer belt (an assistive device which can be used to help safely transfer a person from a bed to a wheelchair, assist with sitting and standing, and help with walking around) was used.</p> <p>Interview with Registered Nurse 1 on November 18, 2024, at 11:16 a.m. confirmed that she should have used a gait belt when assisting Resident 45 from the sitting to standing position and walking her to the bathroom.</p> <p>Interview with the Director of Nursing on November 19, 2024, at 9:03 a.m. confirmed that a gait belt should have been used when Registered Nurse 1 assisted Resident 45 with transferring out of bed to a standing position.</p> <p>28 Pa. Code 211.12(d)(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>48941</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to obtain weights as ordered by the physician for one of 44 residents reviewed (Resident 25) who had weight loss.</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 25, dated October 15, 2024, indicated that the resident was cognitively impaired, was understood and able to understand others, required supervision assist with eating, holds food in mouth/cheeks, was on a mechanically altered diet, had a significant weight loss, received a diuretic medication (a medication used to treat fluid build-up), received oxygen, and had a diagnosis of dementia, depression, anxiety, and respiratory failure (blood does not have enough oxygen and causes difficulty breathing).</p> <p>Physician's orders for Resident 25, dated August 7, 2024, included an order for the resident to be weighed weekly for four weeks with a start date of August 12, 2024, and an end date of September 16, 2024. Review of Resident 25's clinical record revealed no documented evidence that the resident's weight was obtained on August 19, 2024.</p> <p>Physician's orders for Resident 25, dated September 4, 2024, included an order for the resident to be weighed weekly for four weeks with a start date of September 9, 2024, and an end date of October 1, 2024. Review of Resident 25's clinical record revealed no documented evidence that the resident's weight was obtained on September 9, 2024.</p> <p>Physician's orders for Resident 25, dated October 14, 2024, included an order for the resident to be weighed weekly for four weeks with a start date of October 18, 2024, and an end date of November 9, 2024. Review of Resident 25's clinical record revealed no documented evidence that the resident's weight was obtained on October 18, 2024.</p> <p>Physician's orders for Resident 25, dated November 10, 2024, included an order for the resident to be weighed weekly for four weeks with a start date of November 14, 2024, and an end date of December 6, 2024. Review of Resident 25's clinical record revealed no documented evidence that the resident's weight was obtained on November 14, 2024.</p> <p>Interview with the Director of Nursing on November 21, 2024, at 11:02 a.m. confirmed that Resident 25's weights were not obtained as ordered on the above-mentioned dates.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>48941</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the required information was obtained from the contracted hospice provider (provider of end-of-life services) for one of 44 residents reviewed (Resident 94) who was receiving hospice services.</p> <p>Findings include:</p> <p>A facility policy regarding the Hospice Program, dated January 10, 2024, indicated that the hospice agency maintains overall professional management responsibility for directing the implementation of the plan of care related to the terminal illness and related conditions and includes all communication between the hospice and facility when any changes are indicated or made to the plan of care.</p> <p>A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 94, dated October 28, 2024, indicated that the resident was cognitively impaired, required assistance for her daily care needs, had diagnoses that included dementia and Alzheimer's disease, and was receiving hospice services.</p> <p>Physician's orders for Resident 94, dated October 25, 2024, included an order for a hospice consult. A nursing note for Resident 94, dated October 26, 2024, at 7:22 p.m. indicated that the resident was admitted to Gentiva Hospice.</p> <p>The hospice plan of care, dated October 26, 2024, indicated that the home health aide was to see Resident 94 twice weekly starting October 27, 2024, and a registered nurse was to see the resident weekly. As of November 21, 2024, at 12:36 p.m. there was no documented evidence readily available in Resident 94's clinical record, or in the hospice provider's clinical record, of progress notes by the hospice registered nurse since October 27, 2024, or the hospice nurse aide since the start of hospice services on October 26, 2024.</p> <p>Interview with the Director of Nursing on November 21, 2024, at 12:36 p.m. confirmed that the hospice communication records should have been readily accessible in Resident 94's clinical record and they were not. She indicated that it was the facility's practice to obtain paperwork from hospice agencies weekly to put in their hospice binders.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>46994</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to ensure the consistent implementation of infection control procedures designed to prevent the spread of infection during incontinent care for one of 44 residents reviewed (Resident 45).</p> <p>Findings include:</p> <p>Facility policy for handwashing/hand hygiene, dated January 10, 2024, indicated that the facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Hand hygiene is indicated after contact with blood, body fluids, or contaminated surfaces, after touching the resident's environment, before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal.</p> <p>An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 45, dated October 23, 2024, indicated that the resident had moderate cognitive impairment, required partial to moderate assistance from staff for toileting and personal care needs, and had diagnoses that included dementia.</p> <p>Observations of Resident 45 on November 18, 2024, at 11:02 a.m. revealed that Registered Nurse 1 entered the resident's room and assisted the resident to walk to the bathroom. The resident was noted to be continent and incontinent of urine at the time. Registered Nurse 1 removed a soiled brief from the resident and changed the resident's pants that were soiled. She then assisted Resident 45 to a standing position and cleansed the resident's buttocks area and pulled her brief and pants up. Registered Nurse 1 did not remove her gloves and perform hand hygiene prior to assisting the resident to walk to her recliner. Registered Nurse 1 was observed rubbing the resident's back while she walked beside her, then assisted the resident to sit in a recliner with her feet elevated, positioned her over-bed table, and placed a pillow under the resident's feet prior to removing her gloves.</p> <p>Interview with Registered Nurse 1 on November 18, 2024, at 11:16 a.m. confirmed that she should have removed her gloves and completed hand hygiene after providing toileting care to the resident and prior to touching the resident's belongings.</p> <p>Interview with the Director of Nursing on November 19, 2024, at 9:03 a.m. confirmed that Registered Nurse 1 should have removed her gloves and completed hand hygiene after providing toileting care to Resident 45 and prior to touching the resident's belongings.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		