

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395939	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Lehigh LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1718 Spring Creek Road MacUnjie, PA 18062	

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 0584</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 a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>39766</p> <p>Based on observation, it was determined that the facility failed to ensure that a safe, clean, and comfortable environment was maintained in two of two shower rooms. (first-floor central bath and second-floor central bath)</p> <p>Findings include:</p> <p>Observations in the first-floor central bath on July 10, 2024, at 1:15 p.m., and July 11, 2024, at 12:20 p.m., revealed the following:</p> <p>There was a shower chair that had a black substance at the base. A second shower chair had smudges of a brown substance on the seat and a black substance at the base. A bariatric shower chair had hair on the seat and at the bottom of the front base. The wheels on two of the lifts (equipment used to assist residents to a standing position) were dirty.</p> <p>Observations in the second-floor central bath on July 9, 2024, at 1:30 p.m., and July 11, 2024, at 12:00 p.m., revealed the following:</p> <p>The seat of a shower chair was cracked. In the left shower stall, the shower head was leaking. The wheels on three of the lifts were dirty. There was a shower chair that had a black substance under the seat.</p> <p>28 Pa. Code 201.18 (e)(2.1) 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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39766</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment was completed to accurately reflect the resident's current status for one of 24 sampled residents. (Resident 26)</p> <p>Findings include:</p> <p>Clinical record review revealed that on March 11, 2024, a physician ordered for Resident 26 to be provided with hospice services. Review of the MDS assessment dated [DATE], revealed that staff did not indicate that the resident had hospice services in place during the review period. The MDS inaccurately reflected that the resident was not receiving hospice services.</p> <p>In an interview on July 12, 2024, at 9:45 a.m., the Director of Nursing confirmed that the MDS assessment did not identify that Resident 26 received hospice services.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>43883</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to implement physician's orders for one of 24 sampled residents. (Resident 109)</p> <p>Findings Include:</p> <p>Clinical record review revealed that Resident 109 had diagnoses that included congestive heart failure. A physician's order dated May 30, 2024, directed staff to obtain a daily weight and to notify the provider for a weight gain of greater than or equal to two pounds (lbs.) in one day. There was no evidence that staff obtained the resident's weight or that the resident refused to be weighed on June 3, 7, 8, 29, 2024, or July 8, 2024.</p> <p>Further review of the clinical record revealed that on June 24, 2024, the resident weighed 130.1 lbs. and on June 25, 2024, the resident weighed 133.8 lbs., which reflected a 3.7 lb. gain in 24 hours. There was no evidence that staff notified the physician of the weight change of greater than two pounds in one day.</p> <p>In an interview on July 12, 2024, at 9:30 a.m., the Director of Nursing confirmed that there was no evidence that staff offered to weigh the resident on those dates or that the physician was notified of the weight change.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43883</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to implement interventions to prevent further decline and/or improve range of motion for two of 24 sampled residents. (Residents 35, 54)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 35 had diagnoses that included muscle weakness. Review of an occupational therapy discharge assessment dated [DATE], revealed that staff recommended a daily restorative nursing program (RNP) for active range of motion to both arms. There was no evidence that the program was implemented.</p> <p>In an interview on July 12, 2024, at 9:48 a.m., the Director of Rehabilitation Services confirmed that the RNP for active range of motion for Resident 35 was not implemented.</p> <p>Clinical record review revealed that Resident 54 had diagnoses that included dementia, hemiplegia (weakness or paralysis of one side of the body), and a right hand contracture. Review of the MDS assessment dated [DATE], revealed that the resident had cognitive impairment and was dependent on staff for personal hygiene and dressing. On March 27, 2023, the physician ordered for staff to apply a carot splint to Resident 54's right hand at all times. Review of the care plan revealed that the resident had a risk of limitation in movement and the intervention was for staff to apply the splint on her right hand at all times except when care was being provided. Observations on July 9, 2024, at 9:40 a.m., July 10, 2024, at 10:16 a. m. and 2:35 p.m., and July 11, 2024, at 10:15 a.m. and 11:30 a.m., revealed that the resident was in her chair and the right hand carot splint was not in place.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing 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 - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43883</p> <p>Based on observation and interview, it was determined that the facility failed to maintain sanitary conditions in the kitchen.</p> <p>Findings include:</p> <p>Observation in the kitchen on July 9, 2024, at 10:48 a.m., revealed the following:</p> <p>The dish machine failed to achieve the appropriate concentration of sanitizer solution (50-100 parts per million) for three full cycles. There was a black substance on the walls that surrounded the dish machine. There was a back flow of water from a drain on the dish room floor. There was debris on a windowsill in the food preparation area.</p> <p>In an interview, dietary employee 1 stated that she did not check the concentration of the sanitizer solution during operation that morning.</p> <p>In an interview on July 10, 2024, at 11:45 a.m., the Director of Dietary confirmed that staff were to check the concentration of the sanitizer solution of the dish machine while it was operating and accurately record the value on the paper log.</p> <p>28 Pa. Code 201.18(b)(3) Management.</p>