STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395996	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manchester Commons of Presbyterian Seniorcare	6351 West Lake Road Erie, PA 16505

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)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to develop a baseline care plan for one of 19 residents (Resident R65) and failed to provide a resident and his/her representative with a summary of the baseline care plan for one of 19 residents (Resident R175). Findings include: A facility policy entitled Skilled Nursing-Baseline Care Plans dated 2/01/24, revealed a baseline plan of care to meet the resident's immediate needs and provide instructions needed to provide effective and person centered care shall be developed within 48 hours of the resident's admission, and the resident/representative will be provided a summary of the baseline care plans in a form or manner that is easily understood to include initial goals, medications, treatment, and diet. Resident R65's clinical record revealed an admitted [DATE], with diagnoses including acute respiratory failure with hypoxia (a condition where there is not enough oxygen in your body), amyotrophic lateral sclerosis (a nervous system disease that weakens muscles and impacts physical function), severe protein-calorie malnutrition (a form of malnutrition that lacks dietary protein in severe proportions), and gastrostomy (a surgical procedure used to insert a tube through the abdominal wall for nutrition). Review of Resident R65's clinical record lacked evidence that a baseline care plan was developed. During an interview on 8/07/24, at 1:20 p.m. the Director of Nursing (DON) confirmed there was no evidence that a baseline care plan was developed for Resident R65. Resident R175's clinical record revealed an admitted [DATE], with diagnoses including fractured left leg, irregular heartbeat, high blood pressure, heart failure, and speech disturbances. Resident R175's clinical record lacked evidence that a summary of the baseline care plan was provided to Resident R175 and their representative. During an interview on 8/07/24, at 11:00 a.m. the DON confirmed there was no evidence that a summary of the baseline care plan was provided to Resident R175 and their representative. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for one of seven residents observed for medication administration (Resident R227). Findings include: A facility policy entitled Infusion Therapies dated 2/01/24, revealed that flushing is performed prior to each infusion to access vascular device function. The procedure policy revealed to obtain and review a legal prescriber's order. Resident R227's clinical record revealed an admitted [DATE], with diagnoses including spinal abscess, bacterial infection of the backbone, Methicillin Resistant Staphylococcus Aureus (MRSA- type of bacteria that's developed resistance to medications) infection, and resistance to Vancomycin (antibiotic used to treat severe but susceptible bacterial infections) related antibiotics. Resident R227's clinical record contained a physician's order to administer Vancomycin 750 mg intravenously (IV- inserted directly into the vein) every eight hours. There was no physician's order for flushing the IV prior to and after administration of medication. Observation during medication administration on 8/05/24, at 2:05 p.m. revealed that Registered Nurse Employee E1 cleansed Resident R227's IV tubing port and instilled 10 milliliters of saline solution and proceeded to go through the steps of administering the Vancomycin. During an interview on 8/06/24, at 2:39 p.m. the Director of Nursing confirmed that Resident R227's clinical record lacked a physician's order for IV flushes before and after Vancomycin administration. 28 Pa Code 211.12(d)(1)(5) Nursing services 28 Pa Code 211.10(c) Resident care policies

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of facility policy and clinical records, and staff interview, it was determined the facility failed to ensure recommendations made from the consultant pharmacist were acted upon for one of five residents reviewed for unnecessary medications (Resident R36). Findings include: A facility policy entitled Documentation and Communication of Consultant Pharmacy Recommendations dated 2/01/24, revealed that recommendations are acted upon and documented by the community staff and/or the prescriber. Resident R36's clinical record revealed an admitted [DATE], with diagnoses including Lewy Body dementia (disease associated with abnormal deposits of a protein in the brain), high blood pressure, falls, difficulty speaking, and moderate agitation. Resident R36's clinical record revealed a pharmacy consultant recommendation dated 7/03/24, for an Abnormal Involuntary Movement Scale (AIMS-rating scale that was to measure involuntary muscle/nerve movements) assessment be completed. Further review of Resident R36's clinical record revealed a lack of evidence that the pharmacist recommendation dated 7/03/24, for an AIMS assessment was completed by facility staff. During an interview on 8/08/24, at 9:42 a.m. the Director of Nursing confirmed there was no evidence that the pharmacy recommendation for an AIMs assessment for Resident R36 was completed. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based upon observation and staff interview, it was determined that the facility failed to ensure that medications subject to abuse were stored in a separately locked, permanently affixed compartment in one of five medication refrigerators (Blue [NAME]). Findings include: Observation on 8/08/24, at 9:30 a.m. revealed a locked refrigerator in the Blue [NAME] Medication Room that contained an unopened multi-dose vial of liquid Lorazapam (antianxiety medication) that was not stored in a separately locked, permanently affixed compartment. During an interview at the time of the observation, Licensed Practical Nurse Employee E2 confirmed that the refrigerator lacked a separately locked, permanently affixed compartment to store medications subject to abuse. 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655 Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to maintain sanitary food service operations for one of six kitchens (Blue [NAME] kitchen). Findings include: Review of facility policy entitled, Dietary-Sanitization dated 2/01/24, indicated that the dishwashing machines must be operated using the following specifications: High-Temperature Dishwasher (Chemical Sanitization) a. Wash temperature (150 degrees-165 degrees Fahrenheit (F)) for at least forty-five (45) seconds. b. Rinse temperature (165 degrees-180 degrees F) for at least twelve (12) seconds. Upon observation of the Blue [NAME] kitchen dish machine on 8/06/24, at 12:40 p.m. it was confirmed that the dish machine was a High Temperature hot water dishwasher machine. Further observations for approximately 10 minutes at that time, revealed the temperature dial for the rinse cycle was not functioning with the dial needle not moving and resting on 0. During an interview, on 8/06/24, at 12:50 p.m. it was confirmed by the Director of Dining Servcies, that the Blue [NAME] kitchen dish machine temperature for the rinse cycle was unable to be assessed due to the temperature dial not functioning, and additionally was unable to ensure rinse temperatures met the required 180 degrees F for proper sanitation. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.6(f) Dietary services