

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Norriton Square Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Pine Street Norristown, PA 19401	

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 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>43923</p> <p>Based on interview with residents and staff and review of facility documentation, it was determined that facility did not ensure residents were treated with dignity and care in a manner and in an environment that promotes the enhancement of their quality of life related to fresh air breaks for thirteen of 19 residents reviewed (R6, R37, R45, R70, R36, R25, R54, R81, R26, R17, R64, R87, R10)</p> <p>Findings include:</p> <p>On April 3, 2024, at 10:30 a resident council meeting was held with 12 alert and oriented residents (R37, R45, R70, R36, R25, R54, R81, R26, R17, R64, R87, R10) all reported that they have a strong desire to have fresh air brakes during the day. All residents could not recall when they were allowed to go outside besides the leave of absence (LOA) visits upon approval.</p> <p>Three months of Resident Council minute notes were reviewed, and it was noted that on February 29, 2024, that residents requested to have fresh airtime. Four months of activity calendar was reviewed and there were no outside activities noted.</p> <p>On April 3, 2024, at 11:28 a.m. an interview was held with the activity director, Employee E9 who confirmed that there were no fresh air activities per the activity calendar, it was brought to her attention to have fresh airtime and she was planning to implement ones a week.</p> <p>Most recent recreation comprehensive assessments were reviewed for the following residents during the clinical record review, and it was noted:</p> <p>Recreation assessments dated March 13, 2024, resident R6's revealed it's important to be outside to sit and relax. Recreation assessments dated February 27, 2024, resident R64's sitting/relaxing, bird watching/wildlife. Resident enjoys taking part in patio time when offered.</p> <p>Recreation assessments dated February 22, 2024, resident R81's revealed outside time very important and sit and relax.</p> <p>On April 4, 2024, 12:44 p.m. an observation was confirmed with Administrator Employee E1 the facility features a gated courtyard, providing residents with a secure and ample space to enjoy fresh air safely.</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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.29(d) Resident rights

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>29720</p> <p>Based on review of facility policy, observation and staff interview, it was determined that the facility failed to maintain the confidentiality of a resident's medical information on one of two nursing units (third floor).</p> <p>Findings include:</p> <p>Review of facility policy, Health Insurance Portability and Accountability Act (HIPPA) Compliance, reviewed and revised May 1, 2022 revealed, Policy: The Company has a long standing commitment to protecting the privacy of Protected Health Information. The Company also has a further obligation to be compliant with the privacy standards contained in the Health Insurance Portability and Accountability Act of 1996 (HIPPA). The Company has developed policies and procedures to meet the following HIPPA requirements to: 4. Secure patient records containing protected health information such that they are not readily accessible by unauthorized parties.</p> <p>Observation on April 4, 2024 at 9:10 a.m. during Medication Administration revealed Employee E10 picking up the medication cup and proceeding to enter Resident R74's room to deliver medication. Employee E10 left the medication cart unattended with the computer screen open with identifiable information so any passerby could see residential personal and confidential information.</p> <p>Interview on April 4, 2024 at 9:15 a.m. with Employee E10, Registered Nurse, confirmed that the medication cart was left unattended with the computer screen open to reveal Resident's R74 confidential medical information.</p> <p>28 Pa. Code: 211.5(b) Clinical records</p> <p>28 Pa. Code: 201.29 (i) Resident Rights</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>29720</p> <p>Based on review of facility's policies, review of clinical record and interviews with staff, it was determined that the facility failed to ensure that one resident was free from misappropriation of medication for one of 19 residents reviewed (Resident R74).</p> <p>Findings include:</p> <p>Review of facility policy and procedure: Abuse Prohibition, reviewed and revised October 24, 2022, revealed, Centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all patients. Misappropriation of patient property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent.</p> <p>Physician orders for Resident R23 included an order for the resident to receive Eliquis (a blood thinner) 5 milligrams twice per day.</p> <p>Observation of medication administration on April 4, 2024 at 9:40 a.m with Employee E10, licensed nurse, revealed Employee E10 preparing medication for Resident R23 and determining that there was no Eliquis 5 mg available in his drawer. Employee E10 stated, I will just borrow Eliquis from Resident R74. Employee E10 proceeded to remove Eliquis 5mg from Resident R74's medication drawer and administer it to Resident R23.</p> <p>Interview on April 4, 2024 at 10:30 a.m. with Employee E7, Unit Manager, confirmed that this was misappropriation of Resident 74's medication.</p> <p>28 Pa Code 201.14 (a) Responsibility of license</p> <p>28 Pa Code 201.18 (b) (1) Management</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</p> <p>Based on observation, a review of select facility's policy, clinical records review, and staff interviews, it was determined that the facility failed to ensure ongoing evaluation of a resident's need and use of restraints, including evaluation of the least restrictive measure needed to treat the resident's medical symptom for one resident out of 19 sampled residents. (Resident R6)</p> <p>Findings include:</p> <p>A review of a facility policy titled Restraints -Use of, revised on June/15/2022 revealed Patients have the right to be free from any physical or chemical restrains imposed for purposes of discipline or convince, and not required to treat the patient's medical symptoms. Physical Restrain is defined as any manual method, physical or mechanical devise, equipment, or material that meets all of the following criteria: Is attached or adjacent to the patient's body, Cannot be removed easily by the patient, and restricts the patient's freedom of movement or normal access to their body, It further states Patients with a restraints will be re-assessed as follow or per state regulation: monthly for three months, then quarterly, and with any significant change in condition. Additionally, Consent must be obtained prior to the application of the restrain.</p> <p>Clinical record review revealed that Resident R6 was admitted to the facility on [DATE], with the diagnosis of encounter for surgical after care following surgery on the digestive system, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease chronic kidney disease, unspecified severe protein-calorie malnutrition, parkinsonism, dysphagia, restlessness and agitation, age related physical debility, abnormal weight loss.</p> <p>A review of the admission Minimum Data Set Assessment (MDS) - a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 11, 2024, revealed Resident 6's BIMS score was 99 (Brief Interview for Mental Status- a tool to assess cognitive function; a score of 99 indicates that the resident was unable to provide or did not provide answers to complete this section). Continued review of the MDS revealed that Resident R6 did not have any impairments on his upper extremity</p> <p>A physician order indicated on March 9, 2024, to prescribe abdominal binder on at all times. A hospital clinical summary indicated that Resident R6 had a traumatic dislodgement of PEG (percutaneous endoscopic gastrostomy). Taken to OR for ex-Lap, surgical PEG replacement. on February 11, 2024.</p> <p>Observation conducted on April 4, 2024 at 11:13 a.m. with unit manager, Employee E7 revealed that Resident R6 had an abdominal binder around his abdominal area to secure his eternal feed. Resident R6 was not able to easily take off the binder.</p> <p>On April 4, 2024, at 2:35 p.m. a Director of Nursing, Employee E2 and regional nurse, Employee E14 reported that facility did not have a restrain assessment nor consent completed for Resident R6 as they did not recognize that abdominal binder was restrain but was in place to secure the eternal feed.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of occupational therapy assessment dated [DATE], did not indicate any limitation to his upper extremity.</p> <p>Additionally, a thorough review of all clinical record progress notes revealed no documentation indicating that the Resident had removed the abdominal binder. Review of nursing documentation on March 9, 11, 12, 13, 18, 20, 2024 and April 4, 2024 confirmed that the abdominal binder remained in place and that Resident R6 consistently complied with and tolerated the intervention.</p> <p>28 Pa. Code 211.8 (c.1)(f) Use of restraints</p>		

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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>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</p> <p>*Based on review of facility policy and clinical records, and staff interview it was determined that the facility failed to develop a comprehensive care plan for three of 19 residents reviewed (Residents R6, R83, R86).</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident R6 was admitted to the facility on [DATE], with the diagnosis of encounter for surgical after care following surgery on the digestive system, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, chronic kidney disease, unspecified severe protein-calorie malnutrition, parkinsonism, dysphagia, restlessness and agitation, age related physical debility, abnormal weight loss.</p> <p>A review of the admission Minimum Data Set Assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 11, 2024, revealed Resident 6's BIMS score was 99 (Brief Interview for Mental Status- a tool to assess cognitive function; a score of 99 indicates that the resident was unable to provide or did not provide answers to complete this section).</p> <p>A physician order indicated on March 9, 2024, to prescribe abdominal binder on at all times. A hospital clinical summary indicated that Resident R6 had a traumatic dislodgement of PEG. Taken to OR for ex-Lap, surgical PEG replacement. on February 11, 2024.</p> <p>Resident 6's comprehensive care plan, initiated March 9, 2023, did not indicate a any interventions of abdominal binder to be always intact.</p> <p>On April 4 , 2024 a unit manager, Employee E7 confirmed that the was no comprehensive care plan documented for Resident R6. It was observed that Resident R6 had an abdominal binder around his abdominal area to secured his eternal feed.</p> <p>A review of a clinical record indicated that Resident R83 was admitted to the facility on [DATE], with the following diagnosis of anxiety disorder, dementia unspecified severity with other behavioral disturbance, major depressive disorder recurrent, severe with psychotic symptoms, adjustment disorder with depressed mood, disorientation.</p> <p>A further review of the progress notes dated, December 23, 2023, indicated resident visualized w(with)/bed remote at neck, attempting to wrap cord around his neck. Verbalized he wanted to kill himself several times. Staff safety removed, cord, wires, and other self-harm items from within resident's reach .new order to send resident to nearest emergency room for suicide/self-harm attempt.</p> <p>Hospital Discharge summary dated December 29, 2023, indicated Resident R83 was diagnosed with a new diagnosis of suicidal attempt and returned to the facility. Based on the progress note dated, December 29, 2023 facility implemented a physician order to place Resident R83 on 15 minutes checks every shift.</p> <p>(continued on next page)</p>		

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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>Comprehensive care plan dated, September 9, 2023, was reviewed and did not indicate any revision for the new diagnosis of suicidal attempts or 15 minutes checks.</p> <p>On April 5, 2024, Director of Nursing, Employee E2 and Administrator, Employee E1 confirmed that there was no comprehensive care plan developed related to Resident R83 diagnosis of suicidal attempts.</p> <p>During an interview with Resident R86 on April 2, 2024, at 1:39 p.m., the resident stated that she was unsure why she still had a portable oxygen cylinder on the back of her wheelchair, as she had not used supplemental oxygen in months. Observations at the time of the interview revealed that the resident did have an oxygen cylinder on the wheelchair, and that it was not in use at that time.</p> <p>Review of clinical records for resident R86 revealed that she was admitted to the facility on [DATE], with diagnoses including, but not limited to, malignant neoplasm (cancer) of the lung, and acute deep vein embolism (blood clot) of the right lower extremity. Review of physician orders for the resident revealed an order for Oxygen at 2 L/min (liters per minute) via nasal cannula continuously. The order was written on December 22, 2023, and was still active as of April 2, 2024.</p> <p>Review of the care plan for Resident R86 revealed that no care plan had been developed for oxygen usage for the resident.</p> <p>An interview with the Director of Nursing, employee E2, on April 2, 2024, at 2:30 p.m. revealed that the resident only utilized supplemental oxygen when she wants it and that a care plan should be developed of its use for all residents who utilize it. Employee E2 confirmed that no care plan had been developed.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</p> <p>Based on clinical record review, facility policy and interviews with staff, it was determined that the facility did not ensure that a physician order was followed related to unplanned weight loss for one of 19 residents with weight loss reviewed (Resident R6).</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident R6 was admitted to the facility on [DATE], with the diagnosis of encounter for surgical after care following surgery on the digestive system, acute respiratory failure with hypoxia, unspecified severe protein-calorie malnutrition, dysphagia, age related physical debility, abnormal weight loss.</p> <p>A review of the admission Minimum Data Set Assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 11, 2024, revealed Resident 6's BIMS score was 99 (Brief Interview for Mental Status- a tool to assess cognitive function; a score of 99 indicates that the resident was unable to provide or did not provide answers to complete this section).</p> <p>Review of the resident's weight documentation revealed that on March 10, 2024, Resident R4 weighed 147 pounds and on March 21, 2024, the resident weighed 139.2 pounds which was unplanned weight loss of a -5.76% in two weeks.</p> <p>On March 8, 2024, physician order was initiated to get weekly weights x 4 to monitor Resident 6's weight. Clinical record review indicated there was no weekly weight date available between March 21, 2024, to April 4, 2024.</p> <p>On April 4, 2024, at 11:23 a.m. an interview with Registered Dietician, Employee E8 confirmed that there were no weekly weights between March 21, 2024 to April 4, 2024.</p> <p>28 Pa. Code:211.12(d)(5) Nursing services.</p> <p>28 Pa. Code:211.2(a) Physician services.</p> <p>28 Pa. Code 211.5(f) Clinical records</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>29720</p> <p>Based on observation, and interviews with staff, it was determined that the facility failed to maintain an environment free from hazards related to an unlocked medication cart and medication unsecured on the cart for one of two nursing units.</p> <p>Findings include:</p> <p>Observation of medication administration on April 4, 2024 at 9:15 a.m. revealed that the medication cart assigned to Employee E10, licensed nurse, was left on the second floor hallway unattended and unlocked. The cart was observed to have two medications left on top of the cart (Furosemide: a diuretic used to treat fluid retention and Ampicillin: an antibiotic used to treat bacterial infections).</p> <p>Further observation revealed Employee E10 exiting a resident's room and walking down the second floor hallway to the unattended and unlocked medication cart.</p> <p>This observation was confirmed by Employee E10 when she returned to the cart at 9:17 a.m.</p> <p>Continued observation of medication pass revealed Employee E10 preparing medication for Resident R23. Employee E10 pushed medications through several blister packs and turned the blister packs over one by one in a pile on top of the medication cart. Employee E10 turned her back to the cart and proceeded to bring medication to Resident R23. Employee E10 left the cart unlocked with medication on top of the cart and unsecured medication in the cart.</p> <p>This observation was confirmed by Employee E10 when she returned to the cart at 9:30 a.m.</p> <p>28 Pa Code 201.14 (a) Responsibility of license</p> <p>28 Pa Code 201.18 (b)(1)(3) Management</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</p> <p>Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide oxygen as ordered for two of 19 residents (Resident R43, R86).</p> <p>Findings include:</p> <p>Review of the clinical record revealed that Resident R43 was admitted to the facility on [DATE], with the following diagnosis chronic obstructive pulmonary disease with acute exacerbation, acute and chronic respiratory failure with hypercapnia (excessive carbon dioxide in the bloodstream, typically caused by inadequate respiration) and hypoxia (deficiency in the amount of oxygen reaching the tissues)</p> <p>Review of Resident R43's physician's order dated March 5, 2024, indicated to administer three liters of oxygen via nasal cannula continuously.</p> <p>During an observation on April 2, 2024, at 10:15 a.m. Resident R43 observed having oxygen level at 3.5 liter. Then on April 3, 2024, at 4, 2024 at 10:15 a.m. observation was made having oxygen level at 2.5 liter. During the second observation Resident R43 was laying in bed and stated it's been a little tight with not getting enough of oxygen</p> <p>On April 4, 2024, approximately 10:20 a.m. at interview and observation was License Nurse, Employee E5 confirmed Resident R43 was not receiving his oxygen as ordered and increased it to 3 liters.</p> <p>During an interview with Resident R86 on April 2, 2024, at 1:39 p.m., the resident stated that she was unsure why she still had a portable oxygen cylinder on the back of her wheelchair, as she had not used supplemental oxygen in months. Observations at the time of the interview revealed that the resident did have an oxygen cylinder on the wheelchair, and that it was not in use at that time. The nasal cannula tubing was dated as having last been changed on January 1, 2024.</p> <p>Review of clinical records for resident R86 revealed that she was admitted to the facility on [DATE], with diagnoses including, but not limited to, malignant neoplasm (cancer) of the lung, and acute deep vein embolism (blood clot) of the right lower extremity. Review of physician orders for the resident revealed an order for Oxygen at 2 L/min (liters per minute) via nasal cannula continuously. The order was written on December 22, 2023, and was still active as of April 2, 2024. There was also an active order for Oxygen tubing change weekly; label each component with date and initials, written on December 8, 2023.</p> <p>An interview with the Director of Nursing, employee E2, on April 2, 2024, at 2:30 p.m. revealed that the resident only utilized supplemental oxygen when she wants it, that the order should have been modified or discontinued if the resident was no longer utilizing it, and that while orders for its use were active, the cannula should have been changed weekly as ordered by the physician.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>43923</p> <p>Based on observation, review of clinical records, and interviews with residents and staff, it was determined that the facility failed to maintain sufficient nursing staff levels to provide nursing care and services for five of 19 residents reviewed (Residents R80, R78, R90, R73, R198).</p> <p>Findings include:</p> <p>On April 2, 2024, at 11:39 a.m. observation was taken place with Resident R80 who was in bed sleeping and there was a strong odor of feces.</p> <p>On April 2, 2024, at 12:02 p.m. an family interview was held with a Resident R78 who is non-verbal. Family member was observed doing morning care to the resident due to lack of staffing.</p> <p>It was additionally noted that a family member visits 2-3 times a week, and there was an expectation from the staff for her to assist with morning care.</p> <p>On April 2, 2024, at 12:12 p.m. Resident R90 reported facility is short on staffing and need more people.</p> <p>On April 2, 2024, at 12:24 p.m. Resident R73 reported that she did not get a shower for a week and half due to lack insufficient staffing. I returned form leave of absence (LOA) from Easter holiday and did not get a shower before leaving to my sister's house. Resident continued to discuss how shower was important for her before going to Easter celebration; however, they gave me a bed bath, I still didn't get a shower.</p> <p>On April 2, 2024, at 12:40 p.m. an interview was held with assigned nurse aide, Employee E4 to Resident R73 who reported that today her assignment reflected 13/14 residents today, sometimes I have 17 residents to handle. Employee E4 was not aware why Resident R73 didn't get a shower, but many times there are too many residents to care and once lunch time approaches then priority goes to serve the lunch trays verses continuing doing morning care.</p> <p>On April 2, 2024, at 12:24 p.m. interview with Resident R198 who was Resident R73's roommate agreed with Resident R73 that the resident did not get a shower before she went to her sister's house for Easter celebration. Resident R198 reported that she must request morning care because it's not offered each morning. Resident R198 is a new admission and experience lack of response to a call bell. Resident R198 reported a day or so ago, during the night shift she asked to use a bed pan at 2:30 a.m. and fell asleep until a nurse woken her up for medication administration at 5:00 a.m. Resident R198 reported facility needs more people on all shifts.</p> <p>On April 3, 2024, at 10:30 a.m. a resident council meeting was held with 12 alert and oriented residents (Residents R37, R45, R70, R36, R25, R54, R81, R26, R17, R64, R87, R10) all reported that facility lacks sufficient staff, leading to extended period of wait times for their call bells to be answered.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Norriton Square Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Pine Street Norristown, PA 19401	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On April 4, 2024, at 10:48 a.m. an interview with a unit manager Employee E7 confirmed assignment sheet reflected census of 41 residents on the second-floor unit and three nurse aides scheduled; however, one nurse aide arrived to work at 10:00 a.m. There were no residents who received their scheduled showers and other residents did not get their morning care yet.</p> <p>On April 5, 2024, at approximately 10:00 a.m. three weeks of schedules were reviewed and it was confirmed by Administrator, Employee E1 confirmed that facility does not have sufficient number of certified nursing aides, and license nursing employees.</p> <p>28 Pa Code: 211.12 (d)(4) Nursing services</p> <p>28 Pa Code: 201.14(a) Responsibility of licensee</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29720</p> <p>Based on observation, review of facility policy and interview with staff, it was determined that the facility did not ensure that food was served in accordance with professional standards for food service safety for one of 19 residents reviewed (Resident R 47).</p> <p>Findings include:</p> <p>Review of facility policy, Reheating Resident Food and Beverages, revised June 2012, revealed Policy: to reduce the risk of Resident burns related to hot beverages, liquids and food, and to provide guidance on reheating resident food and/or liquids. Staff members only are to reheat resident food and or liquids in the microwave to temperatures that are safe and palatable for residents. Procedure: 2. Items to be reheated are to be covered in the microwave. 4. Locate the dial thermometer available in the reheating area and wash with soap and running water to ensure thermometer is clean. 5. When item reheating is completed, staff member is to use a clean utensil to stir the item or liquid to ensure even heating throughout. The staff member is to use the dial thermometer to ensure the item reaches 165 degrees to prevent food borne illness,</p> <p>Observation of lunch dining on April 2, 2024 at 12:30 revealed Employee E15, dietary aide, plating food for the twenty residents in the dining room. After twelve residents received their meals, Employee E15 ran out of plates and began using white picnic style paper plates. Employee E15, prepared two scoops of mashed potatoes on a paper plate and placed it in the microwave uncovered. Employee E15 then placed the paper plate of reheated mashed potatoes on the counter.</p> <p>Employee E11, nursing aide, picked up the plate and brought the plate to the table where Resident R47 was seated in a geriatric reclining chair. Employee E11 sat by the resident and proceeded to touch the mashed potatoes with her pinky finger. Employee E11 then began feeding the mashed potatoes to Resident R47.</p> <p>Review of Resident R47's clinical record revealed Resident R47 was admitted to the facility on [DATE] with the following diagnoses: hemiplegia and hemiparesis following cerebral infarction (paralysis on one side of the body and muscle weakness or partial paralysis to the other side); aphasia following nontraumatic intracerebral hemorrhage (a language disorder caused by damage in a specific area of the brain that controls language expression and comprehension); hydrocephalus(a build up of fluid in the cavities deep within the brain); Parkinson's Disease (a disorder of the central nervous system that affects movement); apraxia(difficulty with skilled movement), dysphagia (difficulty swallowing); vascular dementia (brain damage caused by multiple strokes) and cognitive communication deficit (difficulty with thinking and how someone uses language). Resident R47 has a BIMS score of 00, indicating severe cognitive impairment.</p> <p>Interview on April 2, 2024 at 1:30 p.m. with Employee E15 revealed, I used paper plates because we ran out of plates. I put the potatoes in the microwave because they weren't hot. I could tell. I forgot to put gravy on them and they were on a paper plate.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Norriton Square Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Pine Street Norristown, PA 19401	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on April 2, 2024 at 1:50 pm with nurse aide, Employee E11 confirmed, I check the temperature of his food by touching with the tip of my little finger. I don't want it to be too hot.</p> <p>Interview on April 2, 2024 at 2:00 p.m. with Employee E16, Food Service Director, revealed We have adequate supplies of plates, bowls, glasses and utensils. Employee E15 did call down to the kitchen to request plates be brought up to the dining room. Gravy was on the steam table. I will inservice our staff about reheating food, having adequate plates and supplies prior to meal time and presenting mashed potatoes with gravy.</p> <p>28 Pa Code 201.14 (a) Responsibility of Licensee</p> <p>28 Pa Code 201.18(b)(3) Management</p> <p>28 Pa Code 211.6 (1)(2) Dietary Services</p>

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</p> <p>Based on review of facility documents and interview with staff, it was determined that the facility failed to report a reportable incident via Event Reporting System to the local Department of Health (DOH) for one of the 19 residents reviewed within the required and appropriate time frames. (Resident R83)</p> <p>Findings include:</p> <p>A review of a clinical record indicated that Resident R83 was admitted to the facility on [DATE], with the following diagnosis of anxiety disorder, dementia unspecified severity with other behavioral disturbance, major depressive disorder recurrent, severe with psychotic symptoms, adjustment disorder with depressed mood, disorientation.</p> <p>A further review of the progress notes dated, December 23, 2023, indicated resident visualized w/bed remote at neck, attempting to wrap cord around his neck. Verbalized he wanted to kill himself several times. Staff safety removed, cord, wires, and other self-harm items from within resident's reach .new order to send resident to nearest emergency room for suicide/self-harm attempt.</p> <p>Hospital Discharge summary dated December 29, 2023, indicated Resident R83 was diagnosed with a new diagnosis of suicidal attempt and returned to the facility. Based on the progress note dated, December 29, 2023 facility implemented a physician order to place Resident R83 on 15 minutes checks every shift.</p> <p>On April 5, 2024, Director of Nursing, Employee E2 and Administrator, Employee E1 confirmed that the facility did not report the incident to the Department of Health.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>		