

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Sterling Health Care and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 318 South Orange Street Media, PA 19063	

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>41765</p> <p>Based on observations and staff interviews, it was determined that the facility failed to maintain a safe and sanitary environment on the patio and loading dock area.</p> <p>Findings include:</p> <p>Observation on the loading dock area conducted on October 22, 2024, at 9:35 a.m., in the presence of Employee E8 revealed 11 cigarette butts scattered on the floor. Employee E8 took a broom and removed the cigarette butts observed on the floor.</p> <p>Observation on the side patio conducted on October 24, 2024, at 9:26 a.m., in the presence of licensed nurse Employee E9 revealed 10 cigarette butts scattered on the floor. Employee E9 reported the cigarette butts are from the employees.</p> <p>Observation on the loading dock area conducted on October 24, 2024, at 9:34 a.m., in the presence of the Housekeeping Director, Employee E10 revealed 16 cigarette butts scattered on the floor.</p> <p>Interview with Employee E10 on October 24, 2024, at 9:40 a.m., revealed side patio and loading dock were cleaned daily but did not get a chance to be cleaned that morning.</p> <p>The above information was conveyed to the Nursing Home Administrator on October 25, 2024, at 11:00 a.m.</p> <p>The facility failed to ensure a safe and sanitary condition on the side patio and loading dock area.</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>41765</p> <p>Based on review of facility policy, clinical records, hospital records, facility investigative documentation, and staff interviews, it was determined the facility failed to provide an environment free from physical abuse and timely abuse reporting for one of 28 residents reviewed (Resident 78). The facility's failure to protect Resident 78 resulted in Resident 78 being sent to the hospital for facial bruising and a hematoma (collection of blood that pools outside of a blood vessel in an organ, tissue, or body space) to the forehead. The facility's failure to timely report the witnessed abuse continued to put Resident 78 and residents from two of four units at risk for further abuse when Employees E3 and E4 continued to provide care. The facility's failure to provide an environment free from abuse and timely notification of witness physical action placed residents at the facility in an Immediate Jeopardy situation. This was identified as a past non-compliance situation.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse, neglect, Exploitation or misappropriation-Reporting and investigating, dated 2001, revealed that if resident abuse, neglect, exploitation, misappropriation of resident property or injury of the unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.</p> <p>Review of Resident 78's diagnosis list revealed the following: Dementia (term used to describe a group of symptoms affecting memory, thinking, and social abilities severely enough to interfere with daily life), Bipolar Disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and Psychosis (severe mental disorder in which thoughts and emotions are so impaired that contact is lost with external reality).</p> <p>Review of Resident 78's Quarterly Minimum Data Set (MDS- standardized assessment tool that measures health status in long-term care residents) dated February 24, 2024, revealed resident had a severe cognitive impairment.</p> <p>Review of Resident 78's care plan initiated in June 2020, revealed resident was non-compliant with hygiene care and getting out of bed. Interventions listed were as follows: Avoid confrontations, speak in a gentle, firm voice when re-directing; explore possible reasons for my resistance to care and adjust; accordingly, and if rejecting re-approach, me later.</p> <p>Review of Resident 78's physician's note dated February 19, 2024, at 3:07 p.m., revealed Resident 78 was seen at the request of nursing after an incident where allegedly a staff punched the resident in the face. Given the resident's dementia, the resident was unable to remember events and complained of mild pain on the right side of the face. The resident had ecchymosis (bruise) to the right eye and a frontal right forehead hematoma. The same note revealed that due to being on anticoagulation and history of trauma by staff, the resident will be sent to ED (Emergency Department) for evaluation and documentation of injury.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident 78's hospital records dated February 19, 2024, revealed resident was seen in the ED because she/he was punched in the right eye and forehead. An imaging of the head was obtained since patient was taking blood thinners which confirmed no signs of bleeding into the patient's brain. Diagnosis was trauma to the eye. The resident was sent back to the facility.</p> <p>Review of facility documentation titled, Resident incident investigation skin breakdown, bruise, skin tear revealed on February 19, 2024, at 8:00 a.m., Resident 78 was observed with a bruise to the right eye and a hematoma to the forehead, the investigation was initiated.</p> <p>Review of the facility's documentation including document titled, Incident Report dated February 19, 2024, at 11:19 a.m., revealed a Nursing Assistant (NA) reported to the charge nurse Resident 78 had been hit by another NA after resident became combative while they were attempting to give care. The same report revealed resident's right eye was black and a large hematoma over the right eye was present.</p> <p>Review of non-licensed Employee E3's statement, completed on February 19, 2024, revealed the date of the incident was February 18, 2024. Employee E3 reported another Nursing Assistant (Employee E4) asked for help with Resident 78's care. The resident was being combative swinging at the NA and then NA swung and hit the resident and then left the room. Employee E3 stated, I was scared to say anything at that time.</p> <p>Review of non-licensed Employee E4's statement, completed on February 19, 2024, revealed on February 18, 2024, Employee E4 was (providing incontinence care) to Resident 78 when she/he became combative, so another NA (Employee E3) was asked to help. The statement further revealed, during the care Employee E4 told Employee E3 to pull Resident 78 over so Employee E4 could change the resident and every time Resident 78 would swing, Employee E4 would cross the residents' arms.</p> <p>Review of non-licensed Employee E5's statement, completed on February 19, 2024, revealed on February 18, 2024, at 2:00 p.m., Employee E5 was working on the first floor when she/he witnessed two nursing employees punch the resident in the face. The statement further revealed both employees punched resident in the face more than once and that they were happy about it. Employee E5 further stated, At first I thought they were playing with the resident, but they were hurting her/him.</p> <p>Review of information dated February 18, 2024, submitted on February 19, 2024, by the facility to Department of Health revealed the alleged incident occurred on February 18, 2024, at 2:00 p.m. The submitted information included, Resident was assessed and has a bruise to her right eye and a hematoma above right eye. Bruise also observed to left eye. The abuse allegation investigation was initiated on February 19, 2024, at 10:18 a.m. Investigation finding revealed Employee E3 reported Employee E4 hit Resident 78 when the resident became combative during care. Resident 78 was swinging her/his arms at staff when Employee E4 swung back hitting the resident. Employee E3 was unable to say the exact location where a resident was hit but was certain Employee E4 hit the resident. During the investigation, the facility identified Employee E5 as being outside the room during the incident. Employee E5 reported observing both Employee E3 and E4 hitting the resident in several places on Resident 78's body.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of facility documentation failed to reveal documentation that Employee E5 reported the witnessed altercation of February 18, 2024, at 2:00 p.m., towards Resident 78 by Employee E3 and E4 until the facility initiated an investigation upon observation of physical signs of trauma to Resident 78's facial area on the morning of February 19, 2024.</p> <p>Review of facility staffing documents revealed both Employees E3 and E4 worked on the first-floor unit with different assigned resident rooms on February 18, 2024, from 7:00 a.m., until 3:00 p.m.</p> <p>Further review of the facility staffing schedules revealed on February 19, 2024, Employee E3 worked on the first-floor unit while Employee E4 worked on the second-floor unit. Both staff worked on February 19, 2024, from 7:00 a.m., until 10:00 a.m., when they were relieved of duty pending outcome of the investigation after abuse allegations were identified by the facility.</p> <p>Review of facility documentation revealed after the witnessed incident by Employee E3 and Employee E4 physically assaulting Resident 78 on February 18, 2024, at 2:00 p.m., Employee E3 continued to monitor and provide as needed care for Resident 78 until the end of the shift at 3:00 p.m.</p> <p>Further review of facility documentation revealed non-licensed Employee E4 continued to provide care for the other residents on her/his assignment, until relieved of duty on February 19, 2024, approximately 10 a.m. , putting residents of assignment at risk of abuse.</p> <p>Additional review of facility documentation revealed that both Employee E3 and E4 returned to the facility to provide care for residents on the first and second floor units, the morning of February 19, 2024, placing these residents at risk and in jeopardy of abuse.</p> <p>An Immediate Jeopardy (IJ) situation was identified by survey team on October 22, 2024, approximately 2:36 p.m. and Immediate Jeopardy template presented to the Nursing Home Administrator (NHA) on October 22, 2024, at 4:00 p.m., related to the witnessed physical abuse of Resident 78. The NHA was made aware that Immediate Jeopardy existed for the facility's failure to provide an environment free from physical abuse and timely reporting of physical abuse placing Resident 78 for further potential abuse and residents on two of four units at risk for possible abuse, an immediate action plan was requested.</p> <p>The facility initially identified the jeopardy on February 18, 2024, after initiating an abuse investigation due to observed bruising on Resident 78's face. The facility initiated and completed an plan of correction on February 24 2024. The survey team requested and received an action plan on October 22, 2024, which included: Assessment of Resident 78, notifying the physician, and sent to the hospital for further assessment and possible treatment as the resident was on an anticoagulant. The facility has terminated the employment of non-licensed Employee E3 and E4. Administration informed Department staff that criminal charges have been filed by the police department. Re-education of Employee E5 on abuse and neglect; a comprehensive house review of all residents was conducted to determine any residents who have injuries of unknown origin to investigate and rule out for abuse; Education was provided to staff before the start of the shift; Reviewed facility policy to ensure appropriateness and completion of the abuse policy, identifying, and reporting of suspected abuse. The policy was reviewed and was deemed appropriate; and monitoring the effectiveness of staff training such as auditing for specified (determined by the facility administration) (questionnaire, on-the-spot, teach back, live drills, etc.) with the results of the audits going to QAPI meeting for review and recommendations.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility's action plan was accepted on October 22, 2024, at 7:30 p.m.</p> <p>On October 23, 2024, upon review of audits, documentation of completed employee education, and interviews with 21 staff members revealed the facility had completed their self-identified interventions developed for their action plan on February 24, 2024.</p> <p>Immediate Jeopardy was lifted on February 24, 2024 then upon review of completion and implementation of facility's action plan which the survey team verified on October 23, 2024, at 11:45 a.m. The Nursing Home Administrator and the Director of Nursing were informed the residents were no longer in immediate jeopardy, past noncompliance.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee Previously cited 8/21/24.</p> <p>28 Pa. Code: 201.18(b)(1) Management Previously cited 8/21/24, 10/27/23, 12/30/22</p> <p>28 Pa. Code: 201.29(a) Resident rights</p> <p>28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services Previously cited 8/21/24, 10/27/23, 12/30/22</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>47968</p> <p>Based on a review of the facility's policy, clinical records, and staff interview, it was determined the facility failed to thoroughly investigate missing personal property for one of the 36 residents reviewed (Resident 136).</p> <p>Findings include:</p> <p>Review of the facility's policy titled Personal Property, dated August 2022, revealed the resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. The facility promptly investigates any complaints of misappropriation or mistreatment of resident property.</p> <p>Review of the facility's policy titled Lost and Found, dated January 2008, revealed that resident or family complaints of missing items must be reported to the Director of Nursing.</p> <p>Review of Resident 136's diagnosis list revealed Major Depression, Anxiety disorder, and Altered Mental Status.</p> <p>Review of Resident 136's Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents), dated July 12, 2024, revealed Resident 136 has a BIMS score of 15 indicating no cognitive impairment.</p> <p>Interview with Resident 136 on October 22, 2024, at 9:55 a.m., revealed a week after admission into facility, family brought in ten clothing outfits that were labeled with the resident's name. When the clothes were sent to laundry they were never returned. Resident 136 stated the missing clothes were reported to nursing staff by the resident and the resident's family. According to Resident 136, clothes from the facility's lost and found were provided as substitutes but Resident 136's clothes were never found or expense reimbursed.</p> <p>During Interview on October 24, 2024, at 9:38 a.m., Employee E7 stated the laundry is outsourced. Employee E7 was aware of Resident 136's missing clothes and indicated laundry services were aware of missing items. Staff have been asked to be on the lookout for Resident 136's clothes as they are labeled with the resident's name. E7 stated staff have put several outfits together from the lost and found for so Resident 136 has something to wear. E7 stated that there should be a grievance form concerning Resident 136's missing clothes.</p> <p>Review of facility documents failed to reveal any grievance or concerns forms related to Resident 136's missing clothes.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on October 24, 2024, at 11:33 a.m., with Nursing Home Administrator (NHA) and Director of Nursing (DON), it was confirmed that complaints of missing items should be reported to the DON and an inventory sheet should be filled out documenting all personal property bought into the facility. The NHA confirmed laundry is outsourced and there have been issues with clothes being lost previously. The facility purchased new color-coded laundry bags for each floor to help prevent clothes from being misplaced. The NHA stated the facility does reimburse residents for missing items. The NHA and the DON both stated they were not aware of Resident 136's missing clothes.</p> <p>During interview on October 25, 2024, at 9:07 a.m., E7 confirmed that Resident 136's inventory sheet had not been updated to include the additional clothing items bought in after admission. E7 stated he/she spoke with Resident 136's family on October 24, 2024, and obtained a list of all missing clothing items.</p> <p>On October 25, 2024, at 12:49 p.m., the NHA and the DON confirmed that staff did not report Resident 136's missing clothes to the DON per facility policy and no grievance form was completed documenting Resident 136's missing clothes.</p> <p>The facility failed to thoroughly investigate Resident 136's missing personal property.</p> <p>28 Pa. Code 201.18(b)(1)(3)(c) Management Previously cited 11/1/21, 12/30/22</p> <p>28 Pa. Code 211.5(f) Clinical records Previously cited 11/1/21, 12/30/22</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services Previously cited 11/1/21, 12/30/22</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>46166</p> <p>Based on review of clinical records and staff interviews, it was determined the facility failed to ensure that physician's orders for wound treatments were followed for one of seven resident reviewed (Resident 9).</p> <p>Findings include:</p> <p>Review of facility policy titled Wound Care most recent date of 2001, revealed staff must verify that there is a physician's order for this procedure and Review the resident's care plan to assess for any special needs of the resident.</p> <p>Interview conducted with Resident 9 on October 22, 2024, at 10:18 a.m. revealed Resident 9 had a bandage on [his/her] right hip covering a surgical incision. Resident 9 reported that [his/her] bandage had not been changed in a few days.</p> <p>Observations conducted of Resident 9's bandage revealed a date of October 17, 2024, written on the bandage.</p> <p>Review of Resident 9's clinical medical record revealed a active physician order dated October 6, 2024, with the following instructions cleanse with normal saline solution (a sterile solution of water and salt), pat dry, apply border dressing daily on Monday-Wednesday-Friday and PRN (as needed).</p> <p>Review of Resident 9's Treatment Administration Record (TAR) for the month of October revealed Resident 9 did not receive wound treatments on October 18, 2024, or October 21, 2024.</p> <p>Interview conducted with the Nursing Home Administrator (NHA) on October 24, 2024, at 11:15 a.m. confirmed the facility failed to provide Physician ordered wound treatment for Resident 9 on October 18, 2024, and October 21, 2024.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0689</p> <p>Level of Harm - 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>46166</p> <p>Based on review of facility policy, clinical record, facility investigation documentation, and staff interviews, it was determined the facility failed to ensure that residents received adequate supervision and assistance to prevent accidents, which resulted in a laceration to the forehead requiring 10 staples to close, for one of seven residents reviewed (Resident 97).</p> <p>Findings Include:</p> <p>Review of Resident 97's clinical record revealed diagnoses including but not limited to; Unspecified Dementia (neurodegenerative disease effecting memory, thinking, and social abilities), lack of coordination, Abnormal posture, muscle weakness, Anxiety disorder, and Intervertebral Disc Degeneration lumbar region (cartilage between the vertebrae begins to deteriorate).</p> <p>Review of Resident 97's risk of falls care plan revealed an intervention, revised March 3, 2023, indicating Resident 97's transfer status is 2 person assists with Hoyer lift into wheelchair.</p> <p>Review of facility policy, titled Mechanical Lift, most recently dated 2016, revealed Guidelines: The portable lift is to be used by two (2) staff (Registered Nurse, Licensed Practical Nurse or nursing assistants) to perform the procedure.</p> <p>Review of information dated August 4, 2024 submitted by the facility on August 5, 2024 revealed on August 4, 2024, at 9:10 a.m. Resident was being transferred by [his/her] cna (certified nurse aide) when [he/she] fell to the floor hitting [his/her] head. Resident has a laceration to [his/her] forehead. Nurse assessed resident and [he/she] has no other injuries observed. CNA stated he transferred the resident alone using a Hoyer lift when he was trying to pull the Hoyer pad and move the Geri chair the resident slid from Hoyer pad falling on to the fall mat. Md (Medical Doctor) and RP (Responsible Party) were notified. Md gave order to send to the ER (emergency room) for evaluation. Incident is substantiated.</p> <p>Further review of information submitted by the facility on August 5, 2024 revealed [Resident 97] returned from the ER (emergency room) with 10 staples in placed and non-adherent dressing. New order to hold [resident's] Plavix for one dose and remove staples in 10 days . New intervention is staff to ensure 2 persons utilized for Hoyer lift transfers.</p> <p>Resident 97 was unavailable for an interview due to scoring a Brief Interview for Mental Status (BIMS) of a 00 (severe impairment).</p> <p>Review of the facility's investigation revealed on August 4, 2024, non licensed Employee E13 provided a written statement stating I tried to transfer the above by using the Hoyer lift .all by myself because all other (nurse aides) were helping with resident trays .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the facility's investigation revealed a written statement from Licensed Practical Nurse (LPN) Employee E12 dated August 4, 2024, stating A staff member came to me and said that a resident had fallen on the floor; however, by the time I got to the room the resident was on [his/her] bed and bleeding from [his/her] head. An assessment was completed for further physical and neurological evaluations.</p> <p>Review of facility's investigation findings revealed, non licensed Employee E13 admitted to transferring Resident 97 independently instead of using a two-person assist with the lift. Employee E13 was terminated after the investigation was completed on August 9, 2024.</p> <p>During an interview with the Nursing Home Administrator (NHA) on October 23, 2024, at 11:03 AM, the NHA stated all transfers conducted with a Hoyer lift require two (2) staff members to assist and confirmed the above findings.</p> <p>Non licensed Employee E13 failed to provide the appropriate assistance level when transferring Resident 97 using a Hoyer lift, resulting in Resident 97 hitting his/her head on the floor, causing a laceration that required 10 staples in the emergency room .</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(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>37789</p> <p>Based on review of facility policy, clinical record, and staff interview, it was determined the facility failed to adequately monitor significant weight changes for two of four residents reviewed for nutrition (Residents 94 and 116).</p> <p>Findings include:</p> <p>Review of facility policy, Weight Assessment and Intervention, last revised March 2022, revealed: Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation.</p> <p>Review of Resident 94's weights revealed that on September 2, 2024, the resident was recorded as weighing 111.5 pounds (lbs.) On September 17, 2024, the resident was recorded as weighing 123.5 lbs., a 12 lb., or 10.76%, weight gain in 15 days.</p> <p>Review of Resident 94's progress notes revealed a Weight Change note from the dietitian dated September 20, 2024, which questioned the accuracy of the September 17th weight and requested a reweight.</p> <p>Further review of Resident 94's weights revealed the next recorded weight on October 8, 2024, where the resident was recorded as weighing 137 lbs., a 13.5 lb., or 9.85% increase, from the previous weight.</p> <p>Further review of Resident 94's progress notes revealed a Weight Change note from the dietitian on October 9, 2024, which stated that the resident's weight gain was falsely elevated due to the resident wearing excessive clothing on the scale, and the dietitian again requested a reweight the following morning.</p> <p>Further review of Resident 94's weights failed to reveal a reweight following the October 8th weight.</p> <p>Interview with the dietitian, Employee E3, on October 25, 2024, at 11:25 a.m., confirmed the facility did not get reweights following Resident 94's significant weight changes.</p> <p>Review of Resident 116's weights revealed that on June 22, 2024, the resident was recorded as weighing 268 lbs. On July 17, 2024, the resident was recorded as weighing 248.2 lbs., a 20 lb., or 7.39%, weight loss in 25 days.</p> <p>Review of Resident 116's progress notes revealed a Weight Change note from the dietitian on July 19, 2024, which questioned the accuracy of the July 17th weight and requested a reweight.</p> <p>Further review of Resident 116's weights revealed the next recorded weight was on August 28, 2024, where the resident was recorded as weighing 260.6 lbs., a 12.4 lb., or 5% increase, from the previous weight.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Sterling Health Care and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 318 South Orange Street Media, PA 19063	

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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>Further review of Resident 116's progress notes revealed no further Weight Change notes from the dietitian.</p> <p>Further review of Resident 116's weights reveal a recorded weight of 260.8 lbs., on September 30, 2024, and 260.8 lbs., on October 1, 2024.</p> <p>Interview with the dietitian, Employee E3, on October 25, 2024, at 11:00 a.m., confirmed the facility did not get reweights following Resident 116's significant weight changes.</p> <p>28 Pa. Code 211.5(f) Clinical Records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p> <p>28 Pa Code: 211.10(c) Resident care policies</p>

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NAME OF PROVIDER OR SUPPLIER Sterling Health Care and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 318 South Orange Street Media, PA 19063	
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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>41765</p> <p>Based on observations and staff interviews, it was determined that the facility failed to maintain safe and sanitary conditions in the kitchen area.</p> <p>Findings include:</p> <p>Observation during a tour of the kitchen was conducted on October 22, 2024, at 10:00 a.m., in the presence of the Dining Director Employee E8. Observation during the tour revealed a black colored substance on the ceiling with peeling white paint above the sink by the dishwasher machine area. Further observation also revealed that the vent right above the dishwasher had a moderate amount of black lint covering the edges of the vent.</p> <p>Interview with Employee E8 conducted on October 22, 2024, at 10:15 a.m., revealed maintenance took care of the ceiling a few months ago. Employee E8 was unable to say how long the black-colored substance on the ceiling above the sink had been present.</p> <p>Observation conducted on October 25, 2024, at 9:21 a.m., revealed the black-colored substance on the ceiling above the sink and the moderate amount of lint on the vent above the dishwasher was still present.</p> <p>Interview with the maintenance staff Employee E11 was conducted on October 25, 2024, at 9:30 a.m. Employee E11 was unable to say how long the black-colored substance on the ceiling above the sink had been present. Employee E11 reported that the ceiling was painted back in April 2024. Employee E11 reported that the black substance on the ceiling was marks from the steam of water which was estimated as 20 feet long in size. Employee E1 reported that the vent above the dishwasher machine was cleaned a few times a year but was unable to say the last time it was cleaned/serviced.</p> <p>The above information was conveyed to the Nursing Home Administrator on October 25, 2024, at 11:30 a.m.</p> <p>28 Pa. Code: 201.18(b)(3) Management</p> <p>28 Pa. Code 211.6(d) Dietary services</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>41765</p> <p>Based on job description reviews, it was determined that the Nursing Home Administrator and Director of Nursing failed to effectively manage the facility by ensuring resident were provided an environment free from abuse or potential of abuse and staff report abuse situations timely.</p> <p>Findings include:</p> <p>Review of the Nursing Home Administrator's (NHA) job description includes the following responsibilities: Operate the facility by the established policies and procedures of the governing body in compliance with federal, state, and local regulations; Establish systems to enforce the facility policies and procedures; Act as liaison to the governing body for the medical, nursing, and other professional staffs and all facility departments; Supervise all depart supervisors and administrative staff; Observe all facility policy and procedures relating to resident's rights; and Assume responsibility for identification, investigation, and follow up on concerns identified in the facility Quality indicator report.</p> <p>Review of the Director of Nursing's (DON) job description includes the following responsibilities: Assume responsibility for the development of nursing service objectives and performance standards of nursing practice for each category of nursing personnel; Assume accountability for the development, organization, and implementation of approved policies and procedures; Direct implementation of Resident [NAME] of Rights; Assume responsibility for nursing service compliance with federal, state, and local regulations; and Follow residents Rights policies at all times.</p> <p>The Nursing Home Administrator and Director of Nursing failed to fulfill their essential job duties and ensure federal and state guidelines and regulations were followed.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services</p> <p>28 Pa Code: 211.10(c) Resident care policies</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>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50032</p> <p>Based on observations and staff interview, it was determined the facility failed to ensure Enhanced Barrier Precautions (infection control prevention designed to reduce transmission of multidrug-resistant organisms in nursing homes) were in place for residents requiring enhanced barrier precautions for one of two residents reviewed (Resident 95).</p> <p>Findings include:</p> <p>Review of the facility's current enhanced barrier precautions policy as revised by the facility dated April 23, 2024, revealed for residents for whom EBP are indicated EBP is employed when performing high contact resident care activities. This includes the use of gown and gloves for the use of accessing a feeding tube.</p> <p>Review of Resident 95's clinical record revealed, Resident was admitted on [DATE], with a diagnosis of Progressive Supranuclear Ophthalmoplegia Steele-[NAME]-Olszewski (rare brain disease that affects walking, balance, eye movements and swallowing) and Dysphagia (difficulty swallowing) Unspecified. The resident required enhanced barrier precautions due to utilizing tube feeding.</p> <p>Observation of Resident 95 on October 22, 2024, at 11:01 a.m. revealed the resident has a feeding tube (tube that is inserted through the abdominal wall and into the stomach. It is used to provide nutrition and fluids to those who are unable to eat/drink normally).</p> <p>Observation of Licensed Nurse Employee E12 on October 23, 2024, at 12:02 pm performing a high contact resident activity of giving a bolus in the feeding tube. Observation of Employee E12 performing the activity, surveyor noted Employee E12 failed to wear a gown as an enhanced barrier precaution.</p> <p>Observation of Resident 95 room on all four days of the survey failed to reveal personal protective equipment located outside the room or signage indicating Resident 95 was on Enhanced Barrier Precautions.</p> <p>Interview with the Director of Nursing and Nursing Home Administrator on October 25, 2024, at 11:15 am. confirmed that Resident 95 was not on Enhanced Barrier Precautions at the time of the survey despite meeting the above criteria.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.</p> <p>28 Pa. Code 211.10(a)(d) Resident care policies</p>		