

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER Green Valley Skilled Nursing and Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Matthew Drive Pottsville, PA 17901	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on observations, a review of clinical records, and resident and staff interviews, it was determined that the facility failed to provide reasonable accommodations to facilitate a resident's participation in activities for one of the 14 residents sampled (Resident 41).</p> <p>Findings include:</p> <p>A clinical record review revealed that Resident 41 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe).</p> <p>A review of an initial comprehensive Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 17, 2024 revealed that Resident 41 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</p> <p>The resident's care plan, initiated February 15, 2023, identified that Resident 41 has a need for socialization and engagement with interventions planned to invite the resident to scheduled activities. Resident 41's activity preferences were identified as bingo, arts and crafts, exercise, singing in church choir, and church or faith based activities.</p> <p>During an interview on March 26, 2024, at 12:00 PM, Resident 41 stated that she doesn't attend many activities because her wheelchair will not pass through the Activity Room door. She explained that once, she sat in the hallway outside the Activity Room during spiritual services and listened the best she could because her wheelchair won't fit through the door.</p> <p>A review of the facility's March 2024 Activity Calendar revealed that approximately 50 activities are scheduled to occur in the facility's Activity Room, including bingo, hymnal singing, and pastoral activities.</p> <p>A review of Resident 41's wheelchair dimensions and specifications revealed that the resident has a bariatric wheelchair with a 30-inch seat. The wheels of the chair extend an additional four inches from the seat on both sides of the chair with an approximate width of the chair at 40 inches.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on March 28, 2024, at approximately 10:15 AM, the Director of Maintenance measured the Activity Room door as 36-inches. During an interview at the same time as the observation, the Director of Maintenance confirmed that Resident 41 was unable to enter the facility's Activity Room because her wheelchair would not fit through the door. He also explained that he was aware of the issue and provided a work order dated March 15, 2024, to address the resident's access to the room, which had yet to be completed as of the time of the survey ending March 28, 2024.</p> <p>During an interview on March 28, 2024, at approximately 9:30 AM, the Nursing Home Administrator (NHA) confirmed that the facility failed to make reasonable accommodations to afford Resident 41 the opportunity to participate in activities of choice.</p> <p>28 Pa. Code 201.29 (a) Resident rights</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on a review of the facility's abuse prohibition policy, select incident reports and clinical records, and interviews with staff and a resident's family, it was determined that the facility neglected to provide the care and services necessary to avoid physical harm and maintain the physical health of one resident out of 14 residents sampled (Resident 33), resulting in an sprained ankle, which caused the resident pain and a decline in abilities to perform activities of daily living.</p> <p>Findings include:</p> <p>A review of the facility policy titled Abuse Policy and Procedure, indicated as last reviewed by the facility on November 1, 2023, revealed that it is the facility's policy to protect residents from neglect and all incidents of suspected neglect will be thoroughly investigated and reported to the Pennsylvania Department of Health and other agencies as directed by law. The policy defines neglect as the failure of the facility, its employees, or service providers to provide services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>A clinical record review revealed that Resident 33 was admitted to the facility on [DATE], with diagnoses that included cerebral ischemia (a condition characterized by impaired blood flow to the brain) and dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 16, 2024 revealed that Resident 33 has severe cognitive impairment with a BIMS score of 05 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 00-07 indicates severe cognitive impairment).</p> <p>The resident's care plan identified that Resident 33 had ADL self-care performance deficit related to dementia and impaired balance, initiated August 14, 2023, with planned interventions that the resident requires the assistance of two staff for toileting.</p> <p>A physician's order was noted on January 3, 2024, indicating that Resident 33 requires two staff for all transfers with a gait belt and rollator walker (a mobility assistance device with wheels).</p> <p>A physician's order was initiated on January 19, 2024, for physical therapy, therapeutic exercise, therapeutic activity, wheelchair training, and gait training.</p> <p>An employee witness statement dated February 29, 2024, provided by Employee A1, nurse aide, revealed that on February 29, 2024, at 9:45 AM, he was transferring Resident 33 from the toilet when the resident's left knee gave out. Employee A1's statement indicated that he then lowered Resident 33 to the floor. The employee's statement indicated that Employee A1 transferred the resident by himself without the assistance of another staff member as the resident required.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated February 29, 2024, at 9:58 AM revealed that Resident 33's left leg gave out while being transferred from toilet to wheelchair. The note indicated that no injuries were identified and that the resident had no complaints of pain.</p> <p>A progress note dated February 29, 2024, at 3:03 PM revealed that Resident 33 was reporting left ankle tenderness, edema, and pain. The resident's left ankle was swollen. The resident's representative was present and indicated that Resident 33 was not able to bear weight on her ankle. The physician ordered that Resident 33 was to receive an X-ray of her left ankle.</p> <p>A progress note dated February 29, 2024, at 5:08 PM revealed that X-ray results were received and no fractures were noted.</p> <p>A review of a facility incident report dated March 1, 2024, revealed that Employee A1, nurse aide, was aware that Resident 33 required the assistance of two staff members for transfers, but Employee A1 felt he was strong enough {to transfer the resident by himself}. The report indicated that Employee A1 received a written disciplinary warning and was educated on following physician orders and care plans. The report also indicated that Resident 33's ankle was sprained with edema and slight redness.</p> <p>A progress note dated March 1, 2024, at 12:30 PM revealed that the resident continued to have left ankle pain. Resident 33's left ankle was wrapped for support, ice was applied, and the leg was elevated. The resident had complaints of pain when bearing weight.</p> <p>A review of the resident's Medication Administration Records for February 2024 and March 2024 revealed that Resident 33 received:</p> <p>Tylenol 325 mg on February 29, 2024, at 2:53 PM with a pain level of 6 out of 10</p> <p>Tylenol 325 mg on February 29, 2024, at 11:57 PM with a pain level of 4 out of 10</p> <p>Tylenol 325 mg on March 1, 2024, at 10:30 AM with a pain level of 6 out of 10</p> <p>Tylenol 325 mg on March 1, 2024, at 3:42 PM with a pain level of 6 out of 10</p> <p>A physician order was initiated on March 2, 2024, for Resident 33 to be transferred with a Hoyer lift until her ankle swelling decreased. The order was discontinued on March 13, 2024.</p> <p>A review of physical therapy treatment encounters revealed that on February 26, 2024, prior to the injury to the resident's ankle, on February 29, 2024, Resident 33 performed gait training for 10 feet, 40 feet, and 30 feet with a front wheeled walker (mobility device) with the assistance of one staff and performed sit-to-stand transfer training with the assistance of one staff. The summary of service indicated that the resident did not experience pain during the session. On February 26, 2024, the resident's progress was discussed with Resident 33's family member. The resident was able to ambulate 15 to 20 feet. The family member indicated that he is hopeful that with continued treatment he will be able to take Resident 33 home. The note indicated that there would be a greater focus on transfer training. The summary of service indicated that the resident did not experience pain during the session.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Therapy documentation indicated that on February 28, 2024, Resident 33 performed sit-to-stand transfer training with minimal staff assistance. The summary of service indicated that the resident did not experience pain during the session.</p> <p>Following the injury to the resident's ankle on February 29, 2024, therapy noted on March 4, 2024, that Resident 33 performed transfer training from sit to stand with moderate assistance from one staff member. During the physical therapy session, the resident complained of a constant stabbing left foot/ankle pain level of 5 out of 10. The summary of service indicated that the resident's left foot pain impacted the therapy session.</p> <p>Therapy noted on March 6, 2024, that Resident 33 performed transfer training from sit to stand with moderate and maximum assistance from one staff member. During the physical therapy session, the resident reported moderate pain in the left ankle/foot. The summary of service indicated that pain limited the resident's ability to transfer and ambulate.</p> <p>Therapy noted on March 8, 2024, that Resident 33 performed transfer training from sit to stand with moderate assistance from one staff member. The resident was able to stand for a maximum of 30 seconds with caregiver assistance. The summary of service indicated that the resident was reporting pain in the left foot that limited transferring and ambulation.</p> <p>A documentation survey report for February 2024 of the activities of daily life tasks walking in the corridor (how the resident walks in the corridor) and walking in the room (how the resident walks in her room) revealed that Resident 33 was able to walk in the facility corridors on 12 occasions with staff assistance and 16 times in her room with staff assistance from February 1, 2024, through February 29, 2024.</p> <p>However, following the resident's ankle injury on February 29, 2024, the documentation survey report for March 2024 for the activities of daily life tasks walking in the corridor and walking in her room revealed that these tasks were not applicable or that the resident was dependent on staff for the activities occurring from March 1, 2024, through March 25, 2024.</p> <p>During an interview on March 26, 2024, at 11:10 AM, Resident 33's family member stated that Resident 33 fell and twisted her ankle a few weeks ago while one staff member was trying to transfer her instead of two people that she requires. He explained that since the resident's fall, Resident 33 has had a setback in her physical rehabilitation. He stated that the resident is now unable to walk as well as she did before the incident. He explained that the goal is for Resident 33 to be discharged home after rehab, but now he's unsure when the resident will have recovered enough to return home.</p> <p>During an interview on March 28, 2024, at approximately 9:30 AM, the Nursing Home Administrator (NHA) confirmed that the facility staff failed to ensure that Resident 33 received the services necessary to avoid physical harm. The NHA confirmed that Employee A1, Nurse Aide, was aware that Resident 33's transfer was to be performed with two people but neglected to assure the presence of a second person and performed the transfer by himself, resulting in Resident 33's sprained ankle and subsequent decline in activities of daily life (i.e. walking in her room and corridor).</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 201.29 (a) Resident Rights</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(5) Nursing Services

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>48277</p> <p>Based on a review of the facility's abuse policy and employee personnel files and staff interview, it was determined that the facility failed to implement their established abuse prohibition procedures for fully screening and training one employee out of five reviewed to ensure that they were eligible for employment in a long-term care nursing facility (Employee 1).</p> <p>Findings include:</p> <p>A review of the facility's policy titled Abuse Policy and Protection last reviewed by the facility November 1, 2023, revealed procedures for screening potential employees for history of abuse, neglect, and misappropriation of property that included protocols for conducting background checks for Federal criminal (if applicable) and State criminal, reference checks to focus on obtaining information from current and previous employers, and verification that all employees with certification or licensure are checked to verify licensure or certification is in good standing. It also indicated in the training procedures that the facility trains employees and volunteers through orientation and annually on issues related to abuse, which includes the facility's abuse prevention policies and procedures.</p> <p>Review of the personnel files of newly hired employees in the last 4 months, provided by the facility during the survey ending March 28, 2024, revealed that Employee 1 (nurse aide) was rehired on December 23, 2023. Employee 1 was initially hired August 16, 2022, and terminated August 18, 2023. There was no documented evidence that the facility obtained an employment application for the December 23, 2023, re-hire of Employee 1. There was no indication that a PA State Police criminal background check was conducted. There was no indication that the facility contacted previous employers to screen for history of abuse or mistreatment. There was no indication that the employee's nurse aide certification was verified. There also was no documentation that Employee 1 had received orientation training to include abuse training, according to facility policy.</p> <p>Interview with Employee 2 (Business Office Manager) on March 27, 2024, at 11:25 AM verified that the facility did not have an application packet for Employee 1's re-hire on December 23, 2023. She indicated that Employee 1 was beyond the 30-day return to work timeframe and that the facility should have obtained a new application. Employee 2 was unable to provide evidence that a PA criminal background check was completed, that previous employers were contacted, and that Employee 1's nurse aide certification was verified. There was also no evidence that Employee 1 received orientation training to include abuse training for the December 23, 2023, employment.</p> <p>28 Pa Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 201.29(a)(c) Resident rights</p> <p>28 Pa. Code 201.20(b)(d) Staff Development</p> <p>28 Pa. Code 201.19 (6)(7)(9)(10) Personnel</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>48276</p> <p>Based on the review of the facility's abuse prohibition policy, clinical records, select facility investigations, and staff interviews, it was determined that the facility failed to timely report an instance of resident neglect to the State Survey Agency for one out of the 14 residents reviewed (Resident 33).</p> <p>Findings include:</p> <p>A review of the facility policy titled Abuse Policy and Procedure, indicated as last reviewed by the facility on November 1, 2023, revealed that it is the facility's policy to protect residents from neglect, and all incidents of suspected neglect will be thoroughly investigated and reported to the Pennsylvania Department of Health and other agencies as directed by law. The policy indicates that the nature of the allegations and the names of the resident(s) and individual(s) implicated will be reported to the Department of Health within five calendar days of the incident.</p> <p>A witness statement dated February 29, 2024, provided by Employee A1, nurse aide, revealed that on February 29, 2024, at 9:45 AM, he was transferring Resident 33 from the toilet when her left knee gave out. Employee A1 indicated that he then lowered Resident 33 to the floor.</p> <p>A progress note dated February 29, 2024, at 9:58 AM revealed that Resident 33's left leg gave out while being transferred from toilet to wheelchair. The note indicated that no injuries were identified and that the resident had no complaints of pain.</p> <p>A progress note dated February 29, 2024, at 3:03 PM revealed that Resident 33 was reporting left ankle tenderness, edema, and pain. The note indicated that the resident's left ankle was swollen. The resident's representative was present and indicated that Resident 33 was not able to bear weight on her ankle.</p> <p>A review of a facility incident report dated March 1, 2024, revealed that Employee A1, Nurse Aide, was aware that Resident 33 required the assistance of two staff members for transfers, but Employee A1 felt he was strong enough {to transfer the resident by himself}. The report indicated that Employee A1 received a written disciplinary warning and was educated on following physician orders and care plans. The report also indicated that Resident 33's ankle was sprained with edema and slight redness.</p> <p>A Fall Committee Meeting Progress note dated March 7, 2024, at 10:33 AM indicated that Resident 33 fell during a transfer and sustained an ankle injury. The progress note indicated that a nurse aide transferred the resident with only one staff member when the resident had physician orders for the use of two staff members. Education was provided to the nurse aide.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on March 28, 2024, at approximately 9:30 AM, the Nursing Home Administrator (NHA) confirmed that the facility staff failed to ensure that Resident 33 received the services necessary to avoid physical harm. The NHA confirmed that Employee A1, Nurse Aide, was aware that Resident 33's transfer was to be performed with two people but neglected to assure the presence of a second person and performed the transfer by himself, resulting in Resident 33's sprained ankle. The NHA confirmed that the neglect of Resident 33 that occurred on February 29, 2024, was not reported to the State Survey Agency within the required time frames.</p> <p>Refer to F600</p> <p>28 Pa Code 201.1 (a) Responsibility of licensee</p> <p>28 Pa Code 201.18 (e)(1) Management</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235</p> <p>Based on review of clinical records and staff interviews, it was revealed that the facility failed to provide therapeutic social services to promote the mental and psychosocial well-being of one resident out of 14 sampled (Resident 8)</p> <p>Findings include:</p> <p>According to regulatory guidance at S483.40(d)</p> <p>Situations in which the facility should provide social services or obtain needed services from outside entities include, but are not limited to the following:</p> <p>Meeting the needs of residents who are grieving from losses and coping with stressful events.</p> <p>Lack of an effective family or community support system or legal representative;</p> <p>Expressions or indications of distress that affect the resident's mental and psychosocial well-being, resulting from depression, chronic diseases (e.g., Alzheimer's disease and other dementia related diseases, schizophrenia, multiple sclerosis), difficulty with personal interaction and socialization skills, and resident to resident altercations;</p> <p>Abuse of any kind (e.g., alcohol or other drugs, physical, psychological, sexual, neglect, exploitation);</p> <p>Difficulty coping with change or loss (e.g., change in living arrangement, change in condition or functional ability, loss of meaningful employment or activities, loss of a loved one); and</p> <p>Need for emotional support.</p> <p>A review of the clinical record revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses to include malignant neoplasm of the colon, chronic obstructive pulmonary disease (COPD), depression and dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 22, 2023, revealed that the resident was moderately cognitively impaired with a BIMS score of 10 (Brief Interview for Mental, which assesses cognition, a tool to assess the resident's attention, orientation, and ability to register and recall new information).</p> <p>The resident's care plan indicated that she has a behavior problem related to verbal and other behaviors, date-initiated June 6, 2023.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>21738</p> <p>Based on staff interview and a review of employee time sheets and qualifications, it was determined that the facility failed to employ a full-time qualified director of food and nutrition services manager in the absence of a full-time qualified dietitian.</p> <p>Findings include:</p> <p>An interview with the food service director (FSD) on March 26, 2024, at 9:30 AM revealed that she was currently enrolled in an online course to become a certified dietary manager and she was presently not qualified for the position according to regulatory criteria.</p> <p>Further interview with the FSD revealed that the facility employed a part-time consultant dietitian who works approximately four hours per week.</p> <p>Review of monthly time sheets for the consultant dietitian dated December 4 through March 22, 2024, confirmed that the consultant dietitian did work four hours per week and was not full-time.</p> <p>Interview with the nursing home administrator (NHA) on March 26, 2024, at approximately 11:30 AM, confirmed that the previous full-time qualified foodservice director's last day of employment was on October 20, 2023. The administrator confirmed that the facility did not currently employ a full-time qualified food service director in the absence of a full-time qualified dietitian.</p> <p>Refer F812</p> <p>28 Pa Code 201.18 (e)(1)(6) Management.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER Green Valley Skilled Nursing and Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Matthew Drive Pottsville, PA 17901	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>21738</p> <p>Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department and resident pantry.</p> <p>Findings include:</p> <p>Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food).</p> <p>According to CMS guidance, dated May 20, 2014 (S & C 14-34-NH) Skilled nursing and nursing facilities should use pasteurized shell eggs or liquid pasteurized eggs to eliminate the risk of residents contracting Salmonella Enteritis (SE). The use of pasteurized eggs allows for resident preference for soft-cooked, undercooked or sunny-side up eggs while maintaining food safety. In accordance with the Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA) standards, skilled nursing and nursing facilities should not prepare nor serve soft-cooked, undercooked or sunny-side up eggs from unpasteurized eggs.</p> <p>Observation during the initial tour of the food and nutrition services department on March 26, 2024, at 9:15 AM revealed two cases of fresh shell eggs, which were not pasteurized (salmonella infections may be prevented by using pasteurized eggs in place of unpasteurized eggs in the preparation of foods where the egg will not be thoroughly cooked) were present on a shelf in the walk-in refrigerator.</p> <p>Interview with the food service director (FSD) at this time confirmed that the fresh shell eggs were being used to serve dippy eggs. The FSD confirmed that the fresh shell eggs were not pasteurized. The FSD confirmed that the fresh shell eggs were ordered by mistake instead of pasteurized shell eggs from the food supplier.</p> <p>Observation of the resident pantry refrigerator on March 26, 2024, at 11:30 AM revealed the following food storage/sanitation concerns:</p> <p>There was a thawed 4-ounce nutritional shake and a 10-gallon plastic bag which contained 4-ounce nutritional shakes in the refrigerator which were not dated with a thaw or discard date. The manufacturer label noted the shakes should be used within 14 days after thawed.</p> <p>There were two plastic storage containers of applesauce on the shelf, which were not dated.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There were two 46-ounce bottles of thickened juice, which were opened but not dated. The manufacturer label noted that the juice should be used within 10 days of opening.</p> <p>There was a 60-ounce bottle of apple juice, which was opened but not dated.</p> <p>There was a spill observed under the plastic pull-out crisper drawer of the refrigerator.</p> <p>Interview with the foods service director (FSD) on March 27, 2024, at 9:30 AM confirmed that food and beverages were to be stored and thawed according to acceptable practices. The FSD confirmed that the food and nutrition services department and resident pantry were to be maintained in a sanitary manner to prevent potential contamination of food and storage items.</p> <p>Refer F801</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</p> <p>28 Pa. Code 211.6 (f) Dietary services</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</p> <p>Based on a review of clinical records and resident and staff interview, it was determined that the facility failed to maintain accurate and complete clinical records consistent with professional standards of practice by failing to timely and accurately document the facility's response to a change in a resident's condition for one resident out of 14 sampled.</p> <p>Findings include:</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care:</p> <p>Assessments</p> <p>Clinical problems</p> <p>Communications with other health care professionals regarding the patient</p> <p>Communication with and education of the patient, family, and the patient ' s designated support person and other third parties.</p> <p>A review of the clinical record revealed that Resident 40 was most recently admitted to the facility on [DATE], with diagnoses that included congestive heart failure (CHF), diabetes, chronic kidney disease, and gastro-esophageal reflux disease (GERD).</p> <p>A quarterly Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated March 3, 2024, indicated that the resident was cognitively intact with a BIMS (brief interview to assess cognitive status) score of 15 (13 - 15 represents cognitively intact), had impairment on both sides with her functional range of motion (ROM) in her lower extremity, and that she required substantial/maximal assistance with her lower body dressing.</p> <p>A nursing note dated March 23, 2024, at 12:53 PM, indicated that the resident's vital signs were stable, continued on a fluid restriction as ordered, laid down after each meal, with feet elevated, left lower leg weeping and monitored. Weight within normal limits. Continues on pain management as ordered. No new areas noted. Nursing noted Will continue to monitor.</p> <p>A review of a nursing note dated March 24, 2024, at 8:15 PM, indicated that the resident had some weeping of the left lower extremity and an dressing (ABD) was applied, loose wrap of cling to contain the drainage.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview Resident 40 on March 26, 2024, at approximately 11:20 AM, in her room, the resident was seated in a wheelchair. The resident stated that her legs are weeping, and showed the surveyor her left lower extremity, which presented clear fluid running down her leg. She stated she was recently hospitalized for congestive heart failure (CHF), had a recent weight gain, and is taking a diuretic (medication to help the body reduce extra fluid from the body). The resident was unsure if the physician was aware of the condition of her legs and the weeping.</p> <p>A nursing note dated March 26, 2024, at 12:12 PM, noted that the resident's bilateral lower legs were edematous and weeping. The resident complained of shortness of breath (SOB). Pulse ox 94 % on room air. Nebulizer treatment was provided as ordered and effective. Nursing noted that the resident had no signs/symptoms distress. The physician was made aware.</p> <p>A nursing note dated March 27, 2024, at 9:41 AM, indicated that the resident's physician was in facility this morning, visited with the resident, and reviewed all lab results. A new order was noted to increase the resident's Trazadone (a medication used to treat depression) to 25 milligram (mg) at bedtime (HS). Nursing noted that the resident was aware of all information.</p> <p>There was no corresponding physician progress note reflecting the contents of this physician visit with the resident and if the physician had discussed the condition of the resident's weeping lower leg with the resident.</p> <p>During a follow-up interview with Resident 40 on March 27, 2024, at approximately 1:35 PM, the resident was seated in a wheelchair in her room, with bilateral cling dressings loosely wrapped down at her ankles. Resident 40 stated last evening some nurse was speaking with her and had applied the dressings and had changed her bedding because of the sheets being wet. The resident further stated she had no recollection of the physician being in to visit her this morning as noted in the nursing progress note or examining her legs earlier this morning. She continued to state, I'm worried about this, pointing to her legs.</p> <p>Interview conducted on March 27, 2024, at approximately 1:45 PM with the Director of Nursing (DON), revealed that the DON stated that she spoke with Resident 40 last evening (March 26, 2024), had applied the dressings, and had changed the resident's bedding because of they were wet. The DON further stated that she had spoken to the physician last evening, and that the physician had been in the facility early this morning. She further acknowledged that there was no documentation of this physician visit however. The DON also noted that there were no current orders for the bilateral legs to be wrapped noted in the resident's clinical record.</p> <p>A review of a late entry nurses note, entered in the resident's clinical record, following surveyor interview with the DON on March 27, 2024, and dated March 26, 2024, at 6:00 PM, revealed spoke to physician regarding weeping legs for 3 days, and resident is uncomfortable with the bed linen now getting wet and she feels it is increasing from her legs. Unable to see exact area where weeping is coming from legs, +2 edema, not warm to touch or reddened, pulse present able to where slippers that were tight dressing was applied to lower legs with abd pad and cling was utilized. Physician is aware to see resident in am, resident was educated on edema present and decrease in fluids and physician to see in AM.</p> <p>A nursing note also dated March 27, 2024, at 1:58 PM, indicated that the resident's physician was aware of legs weeping, orders noted to continue fluid restrictions.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nursing noted on March 27, 2024, at 2:00 PM, that a new order was received to wrap legs with dry dressing at bedtime and that the resident was aware of information.</p> <p>An interview with the Nursing Home Administrator (NHA) on March 28, 2024, at approximately 9:00 AM confirmed that the facility failed to demonstrate that the nursing documentation in the resident's clinical record surrounding the resident's change in condition was not timely, accurate and complete.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 211.5 (f) Medical records</p>		