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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>396088 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>01/26/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Maple Winds Healthcare and Rehabilitation, LLC |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>4112 Spring Hill Road<br>Portage, PA 15946 |  |

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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| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>31760</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to provide a written notice of the facility's bed-hold policy to the resident and/or the resident's representative at the time of transfer for three of three residents reviewed (Residents 1, 2, 3).</p> <p>Findings include:</p> <p>The facility's policy regarding bed holds (holding a resident's bed while the resident is absent from the facility for hospitalization ), dated October 6, 2023, indicated that the admission director/designee will contact the resident/resident's representative following a facility-initiated transfer to an acute care facility or hospital. The original copy of the facility's bed-hold policy was to be placed in the resident's chart and the copy can be given to the family. This can be in person or sent via email. If the representative is present, then they can be informed at that time. Then document in the resident's electronic medical record that the resident/representative was notified either via phone call or in person and received a copy and the original was placed in the chart. When making a phone call to the resident/resident representative to inform them of their options, indicate their choice made on the form. Document on the form that the call was made, and the date and time of the call.</p> <p>Nursing notes for Resident 1, dated January 8, 2024, revealed that the resident was admitted to the hospital on this date. However, there was no documented evidence that a written copy of the facility's bed-hold policy was provided to the resident and/or responsible party at the time of his transfer to the hospital.</p> <p>Nursing notes for Resident 2, dated December 30, 2023, revealed that the resident was admitted to the hospital on this date. However, there was no documented evidence that a written copy of the facility's bed-hold policy was provided to the resident and/or responsible party at the time of her transfer to the hospital.</p> <p>Nursing notes for Resident 3, dated August 9, 2023; November 17, 2023; December 3, 2023; and December 16, 2023, revealed that the resident was admitted to the hospital on those dates. However, there was no documented evidence that a written copy of the facility's bed-hold policy was provided to the resident and/or responsible party at the time of his transfers to the hospital.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some                           | Interview with the Nursing Home Administrator on January 26, 2024, at 1:20 p.m. confirmed that a copy of the facility's bed-hold policy was not provided to Residents 1, 2 and 3 or their responsible parties at the time of their transfers to the hospital.<br><br>28 Pa. Code 201.14(a) Responsibility of Licensee.<br><br>28 Pa. Code 201.18(b)(3) Management. |   |  |

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| <p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>31760</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to permit the readmission of a hospitalized resident without providing evidence that the facility was not able to meet the resident's needs for one of three residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>The facility's policy regarding notice requirements for transfer/discharge of a long-term resident, dated October 6, 2023, indicated that the facility must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident, or the health of individuals in the facility would otherwise be endangered. The facility must also be sure to document the danger that failure to transfer or discharge would pose.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated December 27, 2023, revealed that the resident was understood, understands, exhibited no behaviors, and had diagnoses that included osteomyelitis (a serious infection of the bone that can be either acute or chronic), diabetes, chronic obstructive pulmonary disease (COPD - a group of diseases that cause airflow blockage and breathing-related problems), and acquired absence of the right great toe.</p> <p>A nursing note for Resident 1, dated December 20, 2023, revealed that the resident arrived around 12:45 p. m. via med van in a wheelchair and was alert but confused.</p> <p>Nursing notes for Resident 1, dated December 27, 28, and 30, 2023, and January 3 and 4, 2024, revealed that the resident was being noncompliant with his nonweight bearing status to his right leg and when staff attempted to re-educate and re-direct him, he would become agitated and threaten them.</p> <p>Nursing notes for Resident 1, dated January 6 and 7, 2024, revealed that the resident was being more cooperative with his nonweight bearing status to his right leg.</p> <p>A nursing note for Resident 1, dated January 8, 2024, at 1:59 a.m. revealed that the resident has continuously and purposely gotten out of his bed and gone down to his knees beside his bed on his fall mat and</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>awaits staff intervention (requesting to lift him up). He was assisted to his wheelchair and he was taken to the nurses' station for close observation. The resident would then get up on his own without assistance, would not allow staff to assist him, and states that the staff don't know what the f**k they are doing. At least four staff persons, including this writer, attempted to educate him about his risk of falling and hurting himself, and the safety issues, as well as his increased risk for infection with his foot and walking on a dirty floor with no socks or foot covering. For safety reasons and his continued noncompliance and intentional acting-out behaviors, he will have included in his care plan that he is able to put himself on the fall mat beside his bed. A nursing note at 3:31 a.m. revealed that the nurses responded to the resident's room for the bed alarm sounding between approximately 3:30 a.m. and 4:00 a.m. and the resident was kneeling on the floor. Incontinent care was provided at that time. Approximately five minutes later the bed alarm sounded again, and nursing staff responded to find him kneeling on the floor again. An order was obtained to transport the resident to the hospital for continuing to possibly harm himself as well as having an acute change in mental status. Emergency services (9-1-1) was contacted and the resident was transported out of the facility at approximately 4:30 a.m. A nursing note at 10:18 a.m. revealed that the resident was being admitted to the hospital with a diagnosis of altered mental status and toe infection.</p> <p>There was no documented evidence that the facility could not meet Resident 1's needs related to behaviors, and no documented evidence that the resident's discharge was based on a valid discharge reason. The facility did not wait until he was treated and discharged from the hospital to determine if the facility could not meet the resident's needs.</p> <p>Interview with the Director of Nursing on January 26, 2024, at 2:15 p.m. confirmed that there was no documented evidence in the clinical record of the reasons why the facility was not able to meet the resident's needs. She indicated Resident 1 was very noncompliant and was wandering in other residents' rooms as well as being verbally aggressive toward staff. He also threatened to punch me in the f****g face when I was just trying to get him a drink. We did talk about it as a team and with the physician that we were not able to meet his care needs here at the facility, and that is why it was decided that he would not be able to return here.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management.</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>31760</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain clinical records that were accurately documented for one of three residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated December 27, 2023, revealed that the resident was understood, understands, and had a diagnosis which included osteomyelitis (a serious infection of the bone that can be either acute or chronic) and aquired absence of the right great toe.</p> <p>A wound healing center note for Resident 1, dated January 2, 2024, revealed that staff was to leave the dressing on the resident's foot for three days and then apply betadine dressings daily.</p> <p>Review of Resident 1's Treatment Administration Record (TARs) for January 2024 revealed that staff completed the betadine dressing to the resident's right foot on January 5, 2024. However, there was no documented evidence that the betadine dressing was completed on January 6 and 7, 2024, as per the wound healing center's recommendations.</p> <p>Interview with the Director of Nursing on January 26, 2024, at 12:00 p.m. confirmed that there was no documented evidence that the betadine dressing was completed as per the wound healing center's recommendations on January 6 and 7, 2024.</p> <p>Interview with Registered Nurse 1 on January 26, 2024, at 1:30 p.m. revealed that she completed the betadine dressing to Resident 1's right foot on January 6 and 7, 2024. She indicated that she recalls that the resident was always noncompliant and standing on that foot and that the dressing was off his foot on the 6th, so she went in and completed the treatment. She indicated that she also completed the treatment on the 7th as well.</p> <p>28 Pa. Code 211.5(f) Clinical records.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services.</p> |   |  |