| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396092 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/19/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Village at Penn State, The | 260 Lion's Hill Road<br>State College, PA 16803 |

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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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>36798<br><br>Based on clinical record review, review of facility documents, and staff interview, it was determined that the facility failed to prevent abuse for one of one resident reviewed (Resident 8).<br><br>Findings include:<br><br>Clinical record review for Resident 8 revealed that on May 9, 2024, at 10:30 PM a nurse aide noted her to be sitting on the floor on the left side of her bed. The resident indicated that she slid out of bed. Concurrently, Employee 2, Registered Nurse, was made aware that Resident 8 fell out of bed, and the need to assess her for injuries.<br><br>Review of the facility investigation into the fall revealed that Resident 8 did not have any injuries from the fall but there were concerns documented by Employee 3, nurse aide and Employee 4, Licensed Practical Nurse, that indicated they reported to the Director of Nursing (DON) that when Employee 2 came to assess Resident 8, she was verbally inappropriate to her. The investigation also confirmed that Resident 8 was interviewed and that the nurse was rude and unprofessional.<br><br>Review of a witness statement from Employee 4, dated May 9, 2024, revealed that she notified Employee 2, that Resident 8 slid out of bed and was on the floor and she needed her to come and assess her. Employee 2 was trying to roll Resident 8 on to her side to assess her for injuries and rolled her into the door jamb bumping her right leg very hard . Resident 8 yelled and said it hurt. Employee 2 then yelled at Resident 8 and said, if you are not going to roll, I will mark you as a refusal. I am not hurting my back. Employee 2 rolled Resident 8 again and rolled her against the door jamb very roughly and she yelled again and looked at Employee 3 and said, I hate her.<br><br>Review of a statement from Employee 3 dated May 9, 2024, revealed that when Employee 2 came into the room to examine Resident 8, she seemed very annoyed and spoke in a very rude manner. She indicated that Employee 2 never told Resident 8 that she was going to roll her over, she just tried to flip her over causing her right shin bone to crack off the bathroom door jam. She stated that Employee 2 then proceeded to tell Resident 8 that if she was not going to roll, she would mark her as a refusal. Employee 2 then proceeded to try to roll her again causing her right leg to crack off the door jamb again.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Employee 2's statement dated May 10, 2024, related to this event revealed that she tried to turn Resident 8 to check her back side and right hip, which she said hurt but she kept resisting being turned. Every time she would try to turn Resident 8, she would push back. She indicated that she had an actively dying resident receiving frequent sedation and no licensed practical nurse on duty, so she was passing medications too. She also indicated in her statement that she had been very busy preparing for a long-distance move and was entering the final three days of her nearly 2-month notice. She then stated that she believed this incident was related to stress and frustration due to all these events together and that she was sorry and never meant any harm or disrespect.<br><br>Review of the Director of Nursing's (DON) summary of the event revealed that on May 10, 2024, at 8:30 AM she interviewed Resident 8 who indicated that she slipped out of bed and called for help. Resident 8 indicated that they came and got her up and that another nurse came and was very angry with her for falling out of bed and yelled at her. She said the nurse told her that she broke the rules that were laid out for her and that she was not to go to the bathroom by herself. Resident 8 then indicated that the nurse threw her against the wall. When Resident 8 was assessed, there were no apparent injuries.<br><br>Interview with the DON and Nursing Home Administrator on July 18, 2024, at 12:05 PM revealed that they unsubstantiated the allegation of abuse because Employee 8 did not intend to cause harm. They also indicated that they were going to educate her on recognizing stress and actions to take, but Employee 2 did not return to the facility after the investigation, and that they did not educate other staff responsible for the care of residents related to stress prevention and abuse.<br><br>The facility failed to substantiate verbal and physical abuse related to Resident 8 and failed to educate all staff related to stress management and abuse prevention as it related to this event, to prevent reoccurrence.<br><br>28 Pa. Code 201.18(e)(1) Management<br><br>28 Pa. Code 201.29(a) Resident rights |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>36798<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to monitor for the effectiveness or adverse consequences of psychotropic medication use for one of five residents reviewed (Resident 8).<br><br>Findings include:<br><br>Clinical record review for Resident 8 revealed a current physician's order for Zoloft (a medication used to treat depression) 25 milligrams (mg) one time a day.<br><br>Review of Resident 8's current care plan revealed a care plan focus area for depression related to dementia. The goal was for Resident 8 to remain free of signs and symptoms of depression, anxiety, or sad mood. The interventions indicated to monitor for side effects and effectiveness of the medication.<br><br>Further clinical record review revealed no documented evidence that Resident 8 was being monitored for side effects or effectiveness of the medication.<br><br>Interview with the Director of Nursing and Nursing Home Administrator on July 18, 2024, at 12:15 PM confirmed the above noted findings that there was no documented evidence that they were monitoring Resident 8 for side effects or effectiveness related to her antidepressant medication Zoloft.<br><br>The facility failed to ensure proper monitoring of psychotropic medication use for Resident 8.<br><br>483.45(d)(e)(1)-(2) Drug Regimen is Free From Unnecessary Drugs<br><br>Previously cited deficiency 10/5/2023<br><br>28 Pa. Code 211.9(a)(1)(k) Pharmacy services<br><br>28 Pa. Code 211.10(a) Resident care policies<br><br>28 Pa. Code 211.12(c)(d)(1)(5) Nursing services |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738<br><br>Based on observation and staff interview, it was determined that the facility failed to store food items and maintain a safe and sanitary environment in the main kitchen and smaller kitchen area located on the skilled nursing unit.<br><br>Findings included:<br><br>Initial tour of the facility's main kitchen on [DATE], between 11:10 AM and 11:40 AM with Employee 1, Director of Dining, revealed the following:<br><br>Observation of the walk-in freezer off the hallway revealed:<br><br>A package of veggie burgers was undated, and the package was open exposing them to the ambient air.<br><br>Several packages of what Employee 1 identified as ground pork sausage were undated.<br><br>An undated bag of breadsticks was open to the ambient air.<br><br>Observation of the walk-in cooler off the hallway revealed:<br><br>A package of onions had an expired use-by date of ,d+[DATE].<br><br>Four bags of celery had no dates on them.<br><br>A container labeled plain halibut had an expired use-by date of ,d+[DATE].<br><br>There were eight foil wrapped items in a tray that Employee 1 identified as potatoes with no labels or dates on them.<br><br>There were multiple packaged avocado halves in a box with an expiration date of [DATE].<br><br>Two operating fans on the condenser unit located in the interior of the cooler revealed a significant accumulation of dust.<br><br>Observation of the area that surrounded the main dumpsters to the main kitchen included two medical gloves (one black and one purple) on the ground, three discarded Styrofoam cups/bowls, a significant accumulation of dead leaves, and multiple paper/plastic items discarded behind the recycling dumpster.<br><br>Observation of the walk-in cooler in the main kitchen revealed a partially filled gallon milk container with a sell by date of [DATE], and a container of lemon juice with an expiration date of [DATE].<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The main kitchen had a significant accumulation of dust on a ceiling vent and adjacent ceiling tile above a food prep area. The protective coverings on two of the ceiling lights were partially ajar.<br><br>There was a damaged corner of the wall at the floor between the kitchen and the dishwashing area. A concurrent interview with Employee 1 revealed that maintenance is aware of the issue. Employee 1 further noted that water from the dishwashing area leaks through the damaged wall area and puddles on the floor in the main kitchen area.<br><br>Observation of the smaller kitchen located on the skilled nursing unit between 11:40 AM and 11:50 AM revealed the following:<br><br>A floor drain near the food prep area contained various debris.<br><br>Observation of Employee 5, dish washer, revealed the employee was observed in the kitchen area. Employee 5 had a full beard but did not have a beard guard covering the facial hair. A concurrent interview with Employee 1 revealed that the facility does not require Employee 5 to wear a hair restraining device over his beard.<br><br>An operating air conditioning unit had an extensive build-up of a black colored substance on the vents of the unit.<br><br>The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on [DATE], at 12:08 PM.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee |