

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  396093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Richfield Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  631 Main Street Richfield, PA 17086	

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 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>20725</p> <p>Based on a review of resident personal fund accounting, clinical record review, and resident, family, and staff interview, it was determined that the facility failed to provide a personal fund quarterly statement for two of two residents reviewed for personal funds concerns (Residents 3 and 13).</p> <p>Findings include:</p> <p>Interview with Resident 3's sister on February 4, 2025, at 11:00 AM indicated that the facility automatically receives Resident 3's social security check monthly. Resident 3's sister stated that she did not know what is done with the personal allowance (now 60 dollars) that Resident 3 is permitted to keep each month. Resident 3's sister stated that she does not receive a statement accounting for Resident 3's money.</p> <p>Interview with Resident 3 on February 4, 2025, at 1:50 PM revealed that Resident 3 could not answer if she had a personal fund, where the accounting statement goes, or how much money she had in the account to spend.</p> <p>Review of an accounting statement dated April 1, 2024, to February 13, 2025, revealed that Resident 3 had no debits (withdrawals) from the account with a resulting balance of \$1,772.28.</p> <p>Clinical record review for Resident 13 revealed a, Resident Fund Management Service, authorization (form the facility utilized to document a resident's desire to establish a resident fund account and have social security payments forwarded directly to the facility) signed by Resident 13 on September 11, 2024. The authorization stipulated that Resident 13 would receive a statement of her account at least quarterly.</p> <p>Interview with Resident 13 and her husband on February 4, 2025, at 12:32 PM revealed that Resident 13's social security payment is forwarded to the facility automatically. The interview confirmed that Resident 13 and her husband understood that Resident 13 is allowed to have an amount monthly for a personal allowance and her husband is afforded a spousal support payment each month. Neither Resident 13 nor her husband recalled receiving an accounting statement at least quarterly. Resident 13's husband named Employee 2 (business office manager/human resources director) as the person he would contact for any issues regarding finances.</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 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Employee 2 on February 5, 2025, at 1:26 PM revealed that she did not provide residents with quarterly statements; however, she would have that person speak to the survey team. No facility staff indicated to the survey team that they provided residents their quarterly personal fund statements.</p> <p>Interview with the Nursing Home Administrator on February 5, 2025, at 2:38 PM confirmed that the facility did not have evidence of providing Residents 13 or 3, or their responsible parties, personal fund statements at least quarterly.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to notify a resident and/or their responsible party in writing of a transfer to the hospital with the required information for two of three residents reviewed (Residents 4 and 13).</p> <p>Findings include:</p> <p>Clinical record review for Resident 4 revealed that he was transferred to the hospital from December 3 to 9, 2024, after a change in his condition. There was no documentation that the facility provided written notification to the resident's responsible party regarding the transfer that included the required contents: reason for the transfer, effective date of the transfer, location to which the resident was transferred, a statement of the resident's right to appeal, including the name, contact, email, and address, how to obtain and appeal form, assistance completing and submitting the appeal form and hearing request, contact, email, and address information for the Office of the State Long-Term Care Ombudsman, and information for the agency responsible for the protection and advocacy of individuals with developmental disabilities.</p> <p>Interview with Employee 4 (registered nurse supervisor) on February 5, 2025, at 11:49 AM confirmed the above findings for Resident 4.</p> <p>Interview with Resident 13 and her husband on February 4, 2025, at 12:51 PM indicated that she was admitted to the hospital within the past month. Resident 13's husband could not recall if he received a written notice that included the required contents (e.g., reasons for Resident 13's transfer). Resident 13's husband indicated that he is in the facility four days a week on the days that Resident 13 is not out of the facility for hemodialysis (treatment for kidney failure; a machine filters extra fluid and waste products from the blood).</p> <p>Clinical record review for Resident 13 revealed census information that documented Resident 13 began a hospitalization leave of absence on January 22, 2025.</p> <p>Nursing documentation dated January 29, 2025, at 3:57 PM revealed that Resident 13 returned to the facility from the hospital.</p> <p>A Notice of Transfer or discharge date d January 23, 2025, indicated that the contracted dialysis provider sent Resident 13 to the hospital due to a low blood pressure and confusion on January 22, 2025. There was no evidence that the facility provided Resident 13's husband this notice. The signature line designated for the resident's or resident's representative's acknowledgement of the notice was blank.</p> <p>The surveyor reviewed the above findings regarding Resident 13 during an interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2025, at 12:31 PM.</p> <p>28 Pa. Code 201.14 (a) Responsibility of license</p> <p>(continued on next page)</p>		

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F 0623  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa. Code 201.29(a) Resident rights

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide a written notice of the facility's bed-hold policy to residents or the residents' responsible parties for one of three residents reviewed for hospitalization concerns (Resident 4).</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 4 was transferred to the hospital from December 3 to 9, 2024, after he had a change in condition. There was no documentation available that the facility provided written notice regarding a bed hold to the resident and the resident's responsible party upon transfer out to the hospital.</p> <p>Interview with Employee 4 (registered nurse supervisor) on February 5, 2025, at 11:49 AM confirmed the above findings for Resident 4.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>19719</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessments for one of 12 residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>Review of Resident 1's clinical record revealed a nursing note dated December 22, 2023, indicating that the facility readmitted her from a hospital stay where she was diagnosed with aspiration pneumonia (infection in the lungs) and sepsis (a bloodstream infection).</p> <p>A Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated May 30, 2024, indicated the facility assessed her as having pneumonia, septicemia (a bloodstream infection), and a multidrug resistant organism (MDRO, an infection susceptible to certain antibiotics). There was no documented evidence in Resident 1's clinical record to indicate that she had a current pneumonia infection, septicemia, or an MDRO.</p> <p>MDS Assessments dated August 1, 2024, August 30, 2024, and November 27, 2024, indicate that the facility continued to assess Resident 1's as having pneumonia, septicemia, and an MDRO. There was no documented evidence in Resident 1's clinical record to indicate that she had a current pneumonia infection, septicemia, or an MDRO since December of 2023.</p> <p>Interview with the Administrator on February 5, 2025, at 12:50 PM confirmed that Resident 1's MDS's dated May 30, 2024, August 1, 2024, August 30, 2024, and November 27, 2024, were coded in error regarding having pneumonia, septicemia, and an MDRO.</p> <p>28 Pa. Code 211.5(f)(ix) Medical records</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to implement interventions to prevent future falls or accidents for one of three residents reviewed for falls (Resident 5).</p> <p>Findings include:</p> <p>Clinical record review revealed the facility admitted Resident 5 on November 9, 2017. The facility initiated a care plan noting Resident 5 was at risk for falls on November 27, 2020, due to decreased safety awareness.</p> <p>Nursing documentation dated October 10, 2024, at 5:40 PM noted Resident 5 had an unwitnessed fall. Review of the facility investigation into Resident 5's fall noted he fell out of bed. Resident 5 was found on his right side with his blanket wrapped around him and a 1.8 centimeter (cm) by 0.6 cm abrasion above his ear. The investigation noted no new interventions and indicated staff will discuss at interdisciplinary team meeting (IDT).</p> <p>Nursing documentation dated October 17, 2024, at 2:35 AM noted Resident 5 was found on floor on the left side of his bed, between his bed and closet. Review of the facility investigation into Resident 5's fall revealed the immediate action the facility took was for staff to place a pillow behind Resident 5's upper body while he was in bed to prevent further falls.</p> <p>Nursing documentation dated December 20, 2024, at 1:59 AM revealed Resident 5 was observed laying on his backside on the floor beside his bed. Documentation noted Resident 5 was assisted back to bed and blanket rolls were placed on bilateral sides of his mattress to remind him of the edges of the mattress. Nursing documentation noted Resident 5's care plan was updated.</p> <p>Further review of Resident 5's care plan revealed the nursing staff never updated his care plan with the intervention of placing a pillow behind Resident 5's upper body while in bed, or the blanket rolls on the bilateral sides of Resident 5's mattress while in bed. The only documentation the facility was able to provide related to the IDT meeting regarding Resident 5's fall was noted January 8, 2025, after three falls from his bed occurred.</p> <p>Interview with the Director of Nursing on February 6, 2025, at 11:19 AM confirmed the above findings for Resident 5, and was unable to provide any further documentation that Resident 5's care plan was updated to prevent further falls.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>20725</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure the consultant pharmacist reported irregularities to the attending physician, and that these reports were acted upon, for one of five residents reviewed for medication concerns (Resident 13).</p> <p>Findings include:</p> <p>Consultant pharmacist reports dated July 2, 2024, and October 4, 2024, listed numerous residents who were reviewed during the visits but did not require any recommendations. Resident 13 was not listed in either report.</p> <p>Resident 13's clinical record did not include evidence that a consultant pharmacist reviewed her medication regimen in July 2024, or October 2024. Resident 13's clinical record did not contain a report from the consultant pharmacist for July 2024, or October 2024.</p> <p>Interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2025, at 3:16 PM revealed that the facility did not have a report of the consultant pharmacist's recommendations for July 2, 2024, or October 4, 2024. The interview confirmed that since Resident 13's name was not listed among the residents on the available July 2024, or October 2024 reports, she should have had a recommendation forwarded to her physician for those months.</p> <p>The facility failed to ensure that the consultant pharmacist documented on a separate, written report that was sent to the attending physician, and that the physician documented in Resident 13's medical record that the identified irregularity was reviewed, and what, if any, action was taken to address it, for the months of July 2024, and October 2024.</p> <p>28 Pa. Code 211.9(k) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>20725</p> <p>Based on a review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure a medication error rate below five percent (Residents 2 and 14).</p> <p>Findings include:</p> <p>The facility's medication error rate was eight percent based on 25 medication opportunities with two medication errors.</p> <p>The facility policy entitled, Administering Medications, last reviewed without changes on December 31, 2024, indicated that medications are administered in accordance with prescriber orders. Each nurses' station has a current Physician's Desk Reference (PDR) and/or other medication reference, as well as a copy of the surveyor guidance for pharmacy services available. Manufacturer's instructions or users' manuals related to any medication administration devices are kept with the devices or at the nurses' station.</p> <p>The facility policy entitled, Insulin Administration, last reviewed without changes on December 31, 2024, revealed the nursing staff would have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery systems prior to their use. There was no reference to the administration of insulin via single-patient-use prefilled pens that would include the appropriate technique for priming the disposable needle before use.</p> <p>Clinical record review for Resident 2 revealed an active physician's order for staff to administer two units of Insulin Aspart with Niacinamide (Fiasp FlexTouch, a disposable single-patient-use prefilled pen containing insulin, an injectable hormone used to lower blood sugar) before meals when the blood glucose assessment (small sample of blood obtained via a finger prick is placed on a test strip and read by a glucose meter device) is within the range of 151 to 200 mg/dL (milligrams per deciliter).</p> <p>Manufacturer's instructions for the Fiasp FlexTouch pen stipulate that the user is to prime the pen before each injection. After application of a disposable needle, step seven of the instructions notes to turn the dose selector to select two units. Step eight instructs to hold the pen with the needle pointing up and tap the top of the pen gently a few times to let any air bubbles rise to the top. Step nine instructs to hold the pen with the needle pointing up and press and hold in the dose button until the dose counter shows zero. Step ten, dose selection, instructs to check to make sure the dose selector is set at zero and turn the dose selector to select the number of units you need to inject.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of a medication administration pass on February 4, 2025, at 11:57 AM revealed Employee 1 (licensed practical nurse, LPN) prepared medications for administration for Resident 2. Employee 1 obtained a blood glucose assessment of 199 mg/dL. Employee 1 obtained a Fiasp Flextouch insulin pen and a disposable needle from the medication cart. Employee 1 applied the needle to the tip of the Fiasp Flextouch pen and dialed one unit to prime the needle (returning the reading on the window of the pen to zero). Employee 1, then, dialed two units for administration to Resident 2. Employee 1 did not prime the needle with two units of insulin before preparing the physician ordered dose of two units. Employee 1 entered Resident 2's room and administered the insulin medication into Resident 2's right upper arm.</p> <p>Clinical record review for Resident 14 revealed an active physician's order for staff to administer Polyethylene Glycol (laxative to stimulate bowel movements), 3350 oral powder, 17 grams per scoop; give one scoop by mouth in the afternoon for constipation, mix in four to eight ounces of fluid.</p> <p>Instructions on the Polyethylene Glycol container inform the user to use the cap of the container, fill powder to the top of the cap, to obtain a dose of 17 grams.</p> <p>Continued observation of the medication administration pass on February 4, 2025, at 1:10 PM, revealed Employee 1 prepared Polyethylene Glycol for Resident 14. Employee 1 used a plastic medication cup to determine how much of the medication powder to administer. Employee 1 stated that her goal was to fill the medication cup to just over 15 milliliters. Employee 1 did not use the cap of the Polyethylene Glycol container to measure the dose. Employee 1 mixed the powder in water, entered Resident 14's room, and administered the medication to Resident 14.</p> <p>Interview with Employee 1 on February 4, 2025, at 2:25 PM confirmed that she primed Resident 2's insulin needle with only one unit of insulin. Employee 1 did not have a Fiasp FlexTouch pen package insert or the manufacturer's instructions to know that the proper priming technique required two units. Observation of Resident 14's Polyethylene Glycol container instructions with Employee 1 confirmed that the user is to use the container cap to measure 17 grams of the medication. Employee 1 verified that if she used the medication container cap versus a plastic medication cup, Resident 14 would have received more of the medication powder.</p> <p>The surveyor reviewed the concerns regarding the above medication pass observations during an interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2025, at 12:31 PM.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa. Code 211.10(a)(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>20725</p> <p>Based on a review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure medication was labeled in accordance with accepted professional standards for one of 16 residents reviewed for medication administration (Resident 14).</p> <p>Findings include:</p> <p>The facility policy entitled, Administering Medications, last reviewed without changes on December 31, 2024, indicated that medications are administered in accordance with prescriber orders. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.</p> <p>Clinical record review for Resident 14 revealed an active physician's order for staff to administer Clonazepam (used to control and prevent seizures) oral disintegrating tablet 0.5 milligrams (mg), one tablet by mouth two times a day and two tablets by mouth in the afternoon.</p> <p>Observation of the medication administration pass on February 4, 2025, at 1:10 PM revealed Employee 1 (licensed practical nurse) prepared the Clonazepam 0.5 mg medication for Resident 14. Employee 1 poured two tablets of the Clonazepam medication for administration. The label on the medication instructed staff to administer one tablet by mouth twice daily; and two tablets by mouth at bedtime.</p> <p>Interview with Employee 1 on February 4, 2025, at 2:25 PM confirmed that the Clonazepam label instructed staff to administer one tablet twice a day and two tablets at bedtime; however, that did not agree with the active physician's order for Resident 14. Employee 1 confirmed that the label indicated that the pharmacy filled 30 tablets of this medication on January 24, 2025, and there were 23 tablets available on the date and time of the observation (seven tablets had been administered from this medication supply before Employee 1 removed two additional tablets).</p> <p>The surveyor reviewed the concerns regarding the above medication labeling during an interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2025, at 12:31 PM.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa. Code 211.10(a)(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18229</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to assist residents to obtain routine dental care for two of two residents reviewed (Residents 4 and 3).</p> <p>Findings include:</p> <p>Observation of Resident 4 on February 4, 2025, at 11:42 AM revealed he had several broken and missing teeth. Resident 4 was unable to be interviewed due to his cognitive status.</p> <p>Clinical record review revealed the facility admitted him on February 23, 2024. Review of Resident 4's admission MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated February 29, 2024, revealed staff assessed Resident 4 as having no obvious or likely cavity or broken natural teeth.</p> <p>Further review of Resident 4's clinical record revealed nursing documentation dated January 26, 2025, at 1:54 PM noting Resident 4 reports that he broke a tooth today in the right upper front of his mouth. A tooth was noted to be broken in the front side of Resident 4's mouth.</p> <p>Nursing documentation dated January 27, 2025, at 7:15 AM revealed the Director of Nursing assessed Resident 4's mouth due to the broken tooth. The Director of Nursing noted Resident 4's teeth were obviously decayed.</p> <p>Nursing documentation dated January 30, 2025, at 9:47 PM revealed the registered nurse spoke to Resident 4's wife about his broken tooth. Resident 4's wife stated it was in Resident 4's upper left side of his mouth. His wife stated he does have a tooth on the right side that is broken off, but his wife stated that wasn't new.</p> <p>Further review of Resident 4's clinical record revealed he saw the dentist for a comprehensive assessment on October 7, 2024. There was no documentation that Resident 4 received any prophylactic cleanings of his teeth by a dental hygienist since admission.</p> <p>The facility provided no evidence that Resident 4 received routine prophylactic dental cleanings in the past year as covered under the State plan.</p> <p>Interview with the Director of Nursing on February 6, 2025, at 12:45 PM confirmed these findings.</p> <p>Observation of Resident 3 on February 4, 2025, at 1:51 PM revealed that she had discolored, possibly broken, and missing teeth. Interview with Resident 3 on the date and time of the observation revealed that she believed that she had a tooth that needed pulled (extracted).</p> <p>Clinical record review for Resident 3 revealed progress note documentation by the facility's consultant dentist dated July 29, 2024, that indicated Resident 3 had two non-restorable teeth that was recommended for extraction as needed, and Resident 3 had partial dentition.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Richfield Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  631 Main Street Richfield, PA 17086	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Progress note documentation by the facility's consultant dental hygienist dated September 4, 2024, indicated that Resident 3 received adult prophylaxis (professional dental cleaning).</p> <p>An annual MDS dated [DATE], identified that Resident 3 had obvious, or likely, cavities or broken natural teeth, and the assessment triggered the need for a care plan.</p> <p>A plan of care initiated by the facility on March 24, 2020, to address Resident 3's dental or oral cavity health problem related to possible carious/broken teeth listed interventions that included refer to the dentist/hygienist annually and as needed.</p> <p>Resident 3's clinical record did not provide evidence that the facility provided routine dental services to the extent covered under the State plan (e.g., every six months).</p> <p>The surveyor reviewed the above findings regarding Resident 3 with the Director of Nursing on February 5, 2025, at 2:15 PM.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</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>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>20725</p> <p>Based on review of facility policies and procedures, observation, and staff interview, it was determined that the facility failed to store food in a manner to prevent potential food borne illness in the facility's main kitchen.</p> <p>Findings include:</p> <p>The facility policy entitled, Food Storage, last reviewed without changes on December 31, 2024, revealed that scoops must be provided for flour, sugar, cereals, dried vegetables, and spices. Scoops are not to be stored in the food containers but are kept covered in a protected area near the containers. The Guidelines for Storage, instructed staff to, Date your products with Use by Dates.</p> <p>Observation of the facility's kitchen on February 4, 2025, at 9:50 AM with Employee 3, dietary manager, revealed the following observations:</p> <p>A reach-in refrigerator with the following items:</p> <p>A 46-ounce carton of orange juice labeled as opened on January 4, 2025, and a use by date of January 11, 2025.</p> <p>A portioned serving of applesauce labeled with a use by date of February 1, 2025</p> <p>A portioned serving of mixed fruit with a use by date of February 2, 2025</p> <p>A shelf below a food preparation table contained a 25-pound bin with a white substance identified by Employee 3 as sugar. The scooping utensil used by staff to obtain the food item was stored within the bin in contact with the food product.</p> <p>Interview with Employee 3 on February 4, 2025, at 9:54 AM confirmed that staff are not to store the scooping utensils with food products after use.</p> <p>A food preparation area stored a 20-pound bin of a white substance labeled, thickener. The scoop used by staff to obtain the food product was stored inside the bin in contact with the food product.</p> <p>Observation of a reach-in refrigerator on February 4, 2025, at 10:00 AM revealed a one-gallon container of pickle relish dated December 15, 2024. Interview with Employee 3 at the time of the observation revealed that the date would indicate staff opened the container on that date, and that the item did not have a use by date indicated; however, the item should have been discarded in one month. Kitchen staff referred to the Guidelines for Storage document, which indicated that pickles stored in the refrigerator were good for one month.</p> <p>The surveyor reviewed the above facility kitchen concerns during an interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2025, at 11:00 AM.</p> <p>(continued on next page)</p>		

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F 0812  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	483.60(i) Food safety requirements  Previously cited 3/1/24  28 Pa. Code 201.14 (a) Responsibility of Licensee

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>20725</p> <p>Based on a review of select facility policies and procedures, observation, and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection on one of two nursing units (first floor; Residents 13, 18, 2, 14, 20, and 16).</p> <p>Findings include:</p> <p>The facility policy entitled, Handwashing Policy, last reviewed without changes on December 31, 2024, indicated that the purpose of the policy was to reduce the risk of infection and ensure a safe and hygienic environment throughout the facility. Staff are to use a disposable towel to turn off the faucet as the last step of the handwashing technique.</p> <p>Observation of a medication administration pass on February 4, 2025, at 11:35 AM revealed Employee 1 (licensed practical nurse, LPN) administered medications to Resident 13. Employee 1 washed her hands at a sink in Resident 13's room but used the back of her arm to turn off the faucet.</p> <p>Continued observation of the medication administration pass on February 4, 2025, at 11:44 AM revealed Employee 1 began to prepare medications for administration to Resident 18. Employee 1 stated that she was going to choose to wear a mask, gown, and gloves to enter Resident 18's room because he was experiencing symptoms of potential gastrointestinal infection. After administering Resident 18's medications, Employee 1 removed her mask, gown, and gloves, and washed her hands at a sink in the hallway. Employee 1 used the back of her arm to turn off the faucet after washing her hands.</p> <p>Continued observation of the medication administration pass for Resident 2 on February 4, 2025, at 11:57 AM revealed that Employee 1 donned gloves to obtain a blood glucose assessment (small sample of blood obtained via a finger prick is placed on a test strip and read by a glucose meter device). Employee 1 removed her gloves and washed her hands at a sink in the hallway. Employee 1 used the back of her arm to turn off the faucet after washing her hands. Employee 1 prepared Resident 2's medications, donned gloves, and administered an insulin (injectable hormone used to lower blood sugar) injection into Resident 2's right arm. Employee 1 removed her gloves and washed her hands at a sink in the hallway. Employee 1 used the back of her arm to turn off the faucet after washing her hands.</p> <p>Observation of the medication administration pass on February 4, 2025, at 1:17 PM revealed Employee 1 administered medications to Resident 14. Employee 1 washed her hands in Resident 14's room sink but used the back of her arm to turn off the faucet.</p> <p>Observation of a medication administration pass on February 4, 2025, at 1:31 PM revealed Employee 1 administered medications to Resident 20. Employee 1 washed her hands at a sink in Resident 20's room but used the back of her arm to turn off the faucet.</p> <p>Observation of a medication administration pass on February 4, 2025, at 1:39 PM revealed Employee 1 administered medications to Resident 16. Employee 1 washed her hands at a sink in Resident 16's room but used the back of her arm to turn off the faucet.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Employee 1 on February 4, 2025, at 2:25 PM confirmed that she did not use a disposable towel to turn off the faucet after washing her hands multiple times during the medication administration passes.</p> <p>The surveyor reviewed the concerns regarding handwashing observations during an interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2025, at 12:31 PM.</p> <p>28 Pa. Code 211.10(a)(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		