

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396137	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Athens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 South Main St Athens, PA 18810	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>44738</p> <p>Based on observation and staff interview, it was determined that the facility failed to provide adequate housekeeping and maintenance services to ensure a clean, safe, and comfortable environment on one of two nursing units (Ivy Nursing Unit) and a facility dining room.</p> <p>Findings include:</p> <p>Observation of the facility's dining room located adjacent to the main kitchen on June 12, 2024, at 11:41 AM and June 13, 2024, at 10:40 AM revealed the following: various stains on the floor, the overhead lights had various debris in the protective covers, there were two stained ceiling tiles and one tile had a large crack in it near the middle of the room above where the residents were sitting for lunch service, debris and dust on the windowsills, and multiple dried splash stains on the glass of the windows.</p> <p>Observation of the shower room on June 12, 2024, at 12:26 PM revealed the following: a scratched and marred commode seat, dried and brown colored stains on the commode seat, the area behind the toilet paper roll had chipped paint, dead insects in the protective covering over the ceiling light near the commode, a significant build-up of debris under the blue cushion of the shower gurney, an opening in the brick wall behind the jet tub with an accumulation of cobwebs, various linens discarded on the sink, and a significant build-up of debris in the shower drain.</p> <p>Observation of the shower room on June 13, 2024, at 10:31 AM revealed the same findings as above in addition to the following: different linens on the sink that included seven folded towels and a washcloth and two wash cloths on the rails in the shower room.</p> <p>The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 13, 2024, at 2:15 PM.</p> <p>28 Pa. Code 201.18(b)(3)(e)(2.1) Management</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19719</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide a written notice of transfer that included all the written components to the resident and/or the resident's responsible party and failed to notify the Office of the State Long-Term Care Ombudsman upon transfer to the hospital for six of seven residents reviewed (Resident 37, 59, 3, 19, 34, and 60).</p> <p>Findings include:</p> <p>Review of Resident 37's clinical record revealed that the facility transferred him to the hospital on February 27, 2024. There was no documented evidence that that the facility provided Resident 37 and/or his responsible party with a transfer notice that included all the required contents: State long term care appeal agency or contact and address information for the Office of the State Long-Term Care Ombudsman including email address. There was also no documented evidence that the facility notified the Office of the State Long-Term Care Ombudsman regarding Resident 37's transfer to the hospital on February 27, 2024.</p> <p>Review of Resident 59's clinical record revealed that the facility transferred her to the hospital on March 29, 2024. There was no documented evidence that the facility provided Resident 59 and/or her responsible party with a transfer notice that included all the above components, including notification to the Office of the State Long-Term Care Ombudsman.</p> <p>Interview with the Administrator on June 14, 2024, at 10:49 AM confirmed the above findings for Resident 37 and 59.</p> <p>Clinical record review for Resident 3 revealed nursing documentation dated April 3, 2024, at 1:34 PM that Resident 3 was admitted to the hospital from her appointment with the wound care consultant provider. Resident 3 had a surgical procedure for a below the knee amputation.</p> <p>Nursing documentation dated May 11, 2024, at 1:36 AM revealed that Resident 3 had emesis resembling coffee grounds (indicative of gastrointestinal bleeding), had abdominal discomfort, and staff called emergency transport.</p> <p>An emergency room history and physical dated May 10, 2024, indicated that Resident 3 was admitted from the emergency room .</p> <p>A review of a Bed Hold/Transfer/Therapeutic Leave Notification form (form the facility utilized to communicate to a resident and resident's representative that a resident transferred out of the facility) dated April 3, 2024, and May 10, 2024, included no evidence that the facility provided the State long term care appeal agency or contact and address information for the Office of the State Long-Term Care Ombudsman (including email address) to Resident 3 or her responsible party. There was also no documented evidence that the facility notified the Office of the State Long-Term Care Ombudsman regarding Resident 3's hospitalization s.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review for Resident 19 revealed nursing documentation dated April 15, 2024, at 12:51 PM that Resident 19 had a severe congested cough, difficulty with deep breathing, and chest pain when breathing. The physician instructed staff to send the resident to the emergency room .</p> <p>A review of a Bed Hold/Transfer/Therapeutic Leave Notification form dated April 15, 2024, revealed no evidence that staff provided written notification of the transfer to Resident 19 or Resident 19's representative (daughter) that contained all the required components (e.g., the State long term care appeal agency or contact information for the Office of the State Long-Term Care Ombudsman). There was also no documented evidence that the facility notified the Office of the State Long-Term Care Ombudsman regarding Resident 19's hospitalization .</p> <p>Clinical record review for Resident 34 revealed nursing documentation dated April 6, 2024, at 3:21 PM that Resident 34 had an irregular heart rate (appeared to be atrial fibrillation, an irregular and often very rapid heart rhythm). Nursing documentation dated April 7, 2024, at 8:27 PM revealed that Resident 34 was holding her chest area and requested to go to the emergency room for evaluation. Staff notified the physician and arranged emergency transport to the emergency room .</p> <p>Nursing documentation dated April 20, 2024, at 9:15 PM revealed that staff believed Resident 34 had blood clots from her vaginal opening. Resident 34 left the facility via emergency transport at 9:10 PM. Nursing documentation dated April 21, 2024, at 10:34 AM indicated that the hospital admitted Resident 34 with a urinary tract infection.</p> <p>Review of Bed Hold/Transfer/Therapeutic Leave Notification forms dated April 7, 2024, and April 20, 2024, revealed no evidence that staff provided written notification of Resident 34's transfers to Resident 34 or her responsible party that contained all the required components.</p> <p>Clinical record review for Resident 60 revealed documentation from the certified registered nurse practitioner dated February 8, 2024, at 11:38 AM that Resident 60 had lack of feeling and movement on her right side (change from baseline). Resident 60 was sent to the emergency room for evaluation and treatment.</p> <p>The facility could not provide a Bed Hold/Transfer/Therapeutic Leave Notification form for Resident 60's hospitalization on [DATE], that contained all the required components.</p> <p>Nursing documentation dated May 17, 2024, at 4:27 AM revealed that Resident 60 was very diaphoretic (sweating), had a low-grade temperature of 99.9 (Fahrenheit), and had a deteriorating pressure wound on her coccyx (tailbone) area that was foul-smelling. Nursing documentation dated May 17, 2024, at 7:00 AM indicated that staff made the physician aware of Resident 60's change in condition that included altered mental status, fever, skin ulcer, diaphoresis, and increased confusion. The physician responded with instructions to send Resident 60 to the emergency room for evaluation. Nursing documentation dated May 17, 2024, at 7:35 AM revealed Resident 60 left the facility via emergency transport.</p> <p>Review of a Bed Hold/Transfer/Therapeutic Leave Notification form dated May 17, 2024, revealed no evidence that staff provided written notification of the transfer to Resident 60 or Resident 60's representative (son) that contained all the required components. There was also no documented evidence that the facility notified the Office of the State Long-Term Care Ombudsman regarding Resident 60's hospitalization s on February 8, 2024, or May 17, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>The surveyor confirmed the above findings for Residents 3, 19, 34, and 60 during an interview with the Director of Nursing, the Nursing Home Administrator, and Employee 6, on June 13, 2024, at 2:00 PM.</p> <p>483.15(c)(3) Notice before Transfer</p> <p>Previously cited 7/21/23</p> <p>28 Pa. Code 201.14(a) Responsibility of license</p> <p>28 Pa. Code 201.29(a) Resident rights</p>

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident or resident representative received written notice of the facility bed hold policy at the time of transfer for six of seven residents reviewed for hospitalization concerns (Residents 3, 37, 59, 19, 34, and 60).</p> <p>Findings include:</p> <p>Clinical record review for Resident 3 revealed nursing documentation dated April 3, 2024, at 1:34 PM that Resident 3 was admitted to the hospital from her appointment with the wound care consultant provider. Resident 3 had a surgical procedure for a below the knee amputation.</p> <p>Nursing documentation dated May 11, 2024, at 1:36 AM revealed that Resident 3 had emesis resembling coffee grounds (indicative of gastrointestinal bleeding), had abdominal discomfort, and staff called emergency transport.</p> <p>An emergency room history and physical dated May 10, 2024, indicated that Resident 3 was admitted from the emergency room .</p> <p>A review of a Bed Hold/Transfer/Therapeutic Leave Notification form (form the facility utilized to communicate to a resident and resident's representative that a resident transferred out of the facility) dated April 3, 2024, and May 10, 2024, included no evidence that the facility provided written notification of the state bed-hold policy to either Resident 3 or her representative at the time of Resident 3's hospitalization s.</p> <p>Clinical record review for Resident 19 revealed nursing documentation dated April 15, 2024, at 12:51 PM that Resident 19 had a severe congested cough, difficulty with deep breathing, and chest pain when breathing. The physician instructed staff to send the resident to the emergency room .</p> <p>A review of a Bed Hold/Transfer/Therapeutic Leave Notification form dated April 15, 2024, revealed no evidence that staff provided written notification to Resident 19's representative (daughter) of the state bed-hold policy.</p> <p>Clinical record review for Resident 34 revealed nursing documentation dated April 6, 2024, at 3:21 PM that Resident 34 had an irregular heart rate (appeared to be atrial fibrillation, an irregular and often very rapid heart rhythm). Nursing documentation dated April 7, 2024, at 8:27 PM revealed that Resident 34 was holding her chest area and requested to go to the emergency room for evaluation. Staff notified the physician and arranged emergency transport to the emergency room .</p> <p>Nursing documentation dated April 20, 2024, at 9:15 PM revealed that staff believed Resident 34 had blood clots from her vaginal opening. Resident 34 left the facility via emergency transport at 9:10 PM. Nursing documentation dated April 21, 2024, at 10:34 AM indicated that the hospital admitted Resident 34 with a urinary tract infection.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Bed Hold/Transfer/Therapeutic Leave Notification forms dated April 7, 2024, and April 20, 2024, revealed no evidence that staff provided written notification to Resident 34's representative (sister-in-law) of the state bed-hold policy.</p> <p>Clinical record review for Resident 60 revealed documentation from the certified registered nurse practitioner dated February 8, 2024, at 11:38 AM that Resident 60 had lack of feeling and movement on her right side (change from baseline). Resident 60 was sent to the emergency room for evaluation and treatment.</p> <p>The facility could not provide a Bed Hold/Transfer/Therapeutic Leave Notification form for Resident 60's hospitalization on [DATE].</p> <p>Nursing documentation dated May 17, 2024, at 4:27 AM revealed that Resident 60 was very diaphoretic (sweating), had a low-grade temperature of 99.9 (Fahrenheit), and had a deteriorating pressure wound on her coccyx (tailbone) area that was foul-smelling. Nursing documentation dated May 17, 2024, at 7:00 AM indicated that staff made the physician aware of Resident 60's change in condition that included altered mental status, fever, skin ulcer, diaphoresis, and increased confusion. The physician responded with instructions to send Resident 60 to the emergency room for evaluation. Nursing documentation dated May 17, 2024, at 7:35 AM revealed Resident 60 left the facility via emergency transport.</p> <p>Review of a Bed Hold/Transfer/Therapeutic Leave Notification form dated May 17, 2024, revealed no evidence that staff provided written notification to Resident 60's representative (son) of the state bed-hold policy.</p> <p>The surveyor reviewed the above findings for Residents 3, 19, 34, and 60 during an interview with the Director of Nursing, the Nursing Home Administrator, and Employee 6, on June 13, 2024, at 2:00 PM.</p> <p>Review of Resident 37's clinical record revealed that the facility transferred him to the hospital on February 27, 2024, after a fall with injuries. Resident 37 was admitted to the hospital and returned on March 6, 2024. The facility could not provide a Bed Hold/Transfer/Therapeutic Leave Notification form for Resident 37's hospitalization on [DATE].</p> <p>Review of Resident 59's clinical record revealed that the facility transferred her to the hospital on March 29, 2024. Resident 59 was admitted to the hospital and returned on April 3, 2024. The facility could not provide a Bed Hold/Transfer/Therapeutic Leave Notification form for Resident 59's hospitalization on [DATE].</p> <p>Interview with the Administrator on June 14, 2024, at 10:49 AM confirmed the above findings for Resident 37 and 59.</p> <p>483.15(d) Notice of Bed Hold Policy Before/Upon Transfer</p> <p>Previously cited deficiency 7/21/23</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>(continued on next page)</p>		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.29(f) Resident rights

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>44738</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to complete a restorative nursing program for one of three residents reviewed for activities of daily living concerns (Resident 18).</p> <p>Findings include:</p> <p>Clinical record review for Resident 18 revealed a diagnoses list that included the following: osteoarthritis (a degenerative joint disease) of the knee, abnormalities of gait and mobility, and muscle weakness.</p> <p>Review of the current care plan for Resident 18 revealed the resident requires assistance with walking and transferring. An intervention included one-assist with a rolling walker for mobility.</p> <p>Further review of the current care plan for Resident 18 revealed a restorative nursing program that noted a goal that the resident will ambulate up to 70 feet with a rolling walker, one-assist daily, and a wheelchair to follow for safety. The target date was noted as June 24, 2024. Interventions included the following: allow rest breaks as needed, encourage the resident to ambulate at her own pace, and the resident will ambulate up to 70 feet with a rolling walker/ one-assist daily/ wheelchair to follow for safety.</p> <p>Review of the Physical Therapy Discharge Summary for Resident 18 dated March 22, 2024, at 3:58 PM revealed the discharge recommendation of a restorative nursing program. The restorative program noted the resident will ambulate 70 feet with a rolling walker, one-assist daily, and a wheelchair to follow for safety. The resident's prognosis was noted as Good with consistent staff follow-through.</p> <p>A review of the current tasks for Resident 18 revealed the following nursing restorative task: Resident will ambulate up to 70 feet with rolling walker, one-assist daily, wheelchair to follow for safety.</p> <p>Review of the restorative nursing program documentation for the last 30 days revealed the following:</p> <p>May 16, 22, 25, 2024, no documentation noted to indicate the task was completed as recommended.</p> <p>June 1, 7, 2024, no documentation noted to indicate the task was completed as recommended.</p> <p>The following days were marked by various staff as Not Applicable: May 15, 17, 19, 20, 21, 23, 26, 29, 30, 2024; June 6, 8, 9, 11, 2024.</p> <p>An interview with Employee 7, Director of Therapy, on June 13, 2024, at 11:00 AM revealed that the resident was discharged to the restorative program. Employee 7 was unsure what the documentation of Not Applicable meant and reported that the nurse aides do the restorative program with the residents.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Employee 8, nurse aide, on June 13, 2024, at 11:16 AM revealed that she had documented not applicable on several days because it meant she did not see Resident 18 complete the program during the shift so marked not applicable.</p> <p>The facility failed to complete the restorative nursing program for Resident 18 as recommended by therapy upon discharge from physical therapy.</p> <p>The above information for Resident 18 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 13, 2024, at 2:15 PM.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide the highest practicable care related to intravenous access and an implanted pacemaker for one of 13 residents reviewed (Resident 22).</p> <p>Findings include:</p> <p>The surveyor requested the facility's policy or procedure regarding care and services for the use of a PICC (PICC, long, thin, tube that is inserted through a vein in the arm and passed through to a larger vein near the heart. The line requires careful care and monitoring for complications including bleeding, infection, and blood clots) line during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 6 (clinical consultant) on June 12, 2024, at 2:15 PM, and June 13, 2024, at 2:00 PM.</p> <p>The facility did not provide a policy pertaining to the use of a PICC line during the onsite survey.</p> <p>Information regarding PICC line care available from the Mayo clinic (https://www.mayoclinic.org/tests-procedures/picc-line/about/pac-20468748) instruct that the arm used for the PICC line should be protected (i.e., do not lift heavy objects, do not have blood pressure readings taken from that arm, and avoid submerging the PICC line in water). Risks associated with PICC line use include a blocked or broken PICC line and bleeding.</p> <p>Clinical record review for Resident 22 revealed documentation by the physician dated May 23, 2024, at 11:39 AM that Resident 22 was admitted to the facility with a diagnosis of bacteremia (infection in the blood) and would receive intravenous antibiotics for six weeks. The documentation also included Resident 22's surgical history, which included a pacemaker implantation (small device implanted into the chest used to control and/or monitor the heartbeat).</p> <p>Documentation by the physician dated May 24, 2024, at 2:26 PM included that a PICC site to Resident 22's right upper extremity was clean and dry.</p> <p>Observation of Resident 22 on June 11, 2024, at 12:56 PM revealed a PICC line access site on the inside of his right bicep. Observation of Resident 22 and Resident 22's room revealed no indication of any restrictions preventing use of his right arm for blood pressures or venipunctures (blood draws). There was no emergency equipment readily visible in Resident 22's room in the event of complications from the PICC line access (such as clamps or compression dressing kit in the event of bleeding).</p> <p>Interview with Employee 11 (licensed practical nurse) on June 11, 2024, at 1:02 PM confirmed that there was no signage or information readily visible for caregiving staff to deter the use of Resident 22's right arm. Employee 11 also confirmed that there were no supplies for staff to use in an emergency should a potential complication occur with the PICC line.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Clinical record review for Resident 22 revealed no care plan developed by the facility to address Resident 22's diagnosis of bacteremia, intravenous antibiotic administration, PICC line use, or implanted pacemaker care.</p> <p>The surveyor reviewed the above concerns regarding Resident 22's PICC line and implanted pacemaker during an interview with the Nursing Home Administrator, the Director of Nursing, and Employee 6 (clinical consultant) on June 13, 2024, at 2:13 PM.</p> <p>Physician orders obtained following the surveyor's questioning (dated June 13, 2024) instructed staff to measure the PICC line catheter length on admission and with each dressing change, change needleless connector weekly and as needed, change intermittent tubing every 24 hours, and keep a bag of emergency supplies in Resident 22's room for the PICC line. New physician orders dated June 13, 2024, also instructed staff to arrange a cardiology consult for Resident 22.</p> <p>A plan of care pertaining to Resident 22's implanted pacemaker initiated by the facility on June 13, 2024 (following the surveyor's questioning) included:</p> <p>Resident 22 has a [NAME] pacemaker related to dysrhythmias (an abnormal or irregular heartbeat that can be harmless or serious)</p> <p>Resident 22 has a [NAME] transmitter that must be connected at all times; placed on a nightstand or table close to the bed</p> <p>The [NAME] home transmitter front needs to be facing the resident for it to properly read the device</p> <p>Scheduled sessions and device checks occur automatically if requested by your doctor or clinic. How often the [NAME]@home transmitter collects data from your implanted device is determined by your doctor or clinic. Commonly, the information transfer occurs sometime during the night while you sleep</p> <p>Observation of Resident 22's room on June 14, 2024, at 9:43 AM revealed a machine on the bedside table with the name, [NAME], on it. Interview with Resident 22 on the date and time of the observation indicated that staff questioned him the previous day about his pacemaker monitoring; and he told them that he had a monitoring machine at home. Resident 22 stated that staff put the machine in his room the day before (June 13, 2024).</p> <p>Interview with the Director of Nursing on June 14, 2024, at 10:28 AM confirmed that she interviewed the resident and determined that he had a monitoring machine at his home. Facility staff contacted Resident 22's wife and arranged for facility staff to pick up the monitoring machine from Resident 22's house; and staff brought the machine to the facility on [DATE].</p> <p>483.25 Quality of Care</p> <p>Previously cited deficiency 2/7/24</p> <p>28 Pa. Code 211.10(a)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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NAME OF PROVIDER OR SUPPLIER Athens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 South Main St Athens, PA 18810	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>19719</p> <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to provide treatment and services to promote healing and prevent infections regarding pressure ulcers for two of seven residents reviewed (Residents 58 and 59).</p> <p>Findings include:</p> <p>Review of Resident 58's clinical record revealed a physician's order dated March 16, 2024, indicating that nursing staff were to perform wound care to Resident 58's coccyx (sacral area) wound twice a day by packing the wound with half strength betadine-soaked gauze and a dry dressing.</p> <p>Review of Resident 58's Treatment Administration Record (TAR, a form utilized to document the completion of treatments) dated March 2024, revealed that nursing staff did not complete the treatments on the evening of March 16, 2024, and March 18, 2024, the morning of March 19, 2024, and March 21, 2024. There was no additional documented evidence to indicate that nursing staff completed Resident 58's wound care as ordered by her physician.</p> <p>Review of Resident 58's weekly wound assessments revealed that the wound consultant assessed her sacral pressure ulcer on March 25, 2024, as being a Stage 4 (full thickness tissue loss with exposed bone, muscle, or tendon) measuring 10 cm (centimeter) by 8 cm by 1 cm. There was no documented evidence that the facility assessed or measured Resident 58's sacral pressure area until the wound consultant completed it on April 23, 2024. There was no documented evidence to indicate that the facility assessed and measured Resident 58's coccyx wound the week of April 1, April 8, or April 15, 2024.</p> <p>Review of Resident 59's clinical record revealed a physician's order dated March 19, 2024, that indicated nursing staff were to cleanse her sacral wound with normal saline, apply betadine, and a border lite dressing twice a day. Review of Resident 59's TAR dated March 2024, revealed that nursing staff did not complete the treatments on the evening of March 22, 2024, and the morning of March 27, 2024.</p> <p>A physician's order dated April 4, 2024, indicated that nursing staff were to change Resident 59's sacral wound dressing twice a day by packing it with betadine and saline gauze and cover with a dry dressing. Review of Resident 59's TAR dated April 2024, revealed that nursing staff did not complete the treatment on the evenings of April 23, 2024, and April 24, 2024. Review of Resident 59's TAR dated May 2024, revealed that nursing staff did not complete the treatment on the evenings of May 1, 2, 8, and 14, 2024.</p> <p>Observation on June 13, 2024, at 10:10 AM revealed Employee 1, licensed practical nurse, performing wound care for Resident 59's sacral wound. Employee 1 gathered all the dressing care supplies with gloved hands. Employee 1 placed supplies on top of Resident 59's bed side table, while preparing a field on top of Resident 59's bed. Employee 1 used the same gloved hands to open dressing supplies, and placed gauze into a betadine solution. Employee 1 used the same gloved hands to clean Resident 59's wound and placed the betadine-soaked gauze into her wound. Interview with Employee 1 at this time revealed that she should have changed her gloves and washed her hands between gathering supplies and before applying a clean dressing to Resident 59's wound.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Director of Nursing on June 14, 2024, at 10:20 AM confirmed the above findings for Residents 58 and 59.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>19719</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide physician ordered interventions for two of six residents reviewed for nutritional risk (Residents 25 and 59).</p> <p>Findings include:</p> <p>Review of Resident 25's plan of care dated August 6, 2020, and last revised on December 25, 2023, indicated that the facility determined he was a nutritional risk. The facility indicated that an intervention of a nutritional supplement would benefit him and maintain his skin integrity.</p> <p>A physician's order dated July 25, 2023, indicated that nursing staff were to provide 8 oz (ounces) of Boost (a nutritional supplement) twice a day.</p> <p>Review of Resident 25's Medication Administration Record (MAR, a form utilized to document the administration of select physician orders) dated April 2024, indicated that nursing staff did not give him the Boost five times, documenting that it was unavailable or on order. Review of Resident 25's MAR dated May 2024, indicated that nursing staff did not give him the Boost 26 times documenting that it was unavailable, none in facility, or on order.</p> <p>A dietary note dated May 28, 2024, indicated that Resident 25 prefers to follow a high protein diet and to continue using Boost, as Resident 25 has a history of skin breakdown. Nursing documentation dated June 7, 2024, at 9:51 PM indicated that nursing staff found a small open area on Resident 25's scrotum.</p> <p>Review of Resident 59's clinical record revealed a dietary note dated March 26, 2024, indicating that Resident 59 had an open wound and recommended to start Boost twice a day. A physician's order dated April 4, 2024, indicated that nursing staff were to provide Boost before meals. Review of Resident 59's MAR dated April 2024 indicated that nursing staff did not give her the Boost seven times documenting that it was unavailable. Review of Resident 59's MAR dated May 2024, indicated that nursing staff did not give her the Boost 31 times documenting that it was unavailable.</p> <p>A dietary note dated May 7, 2024, indicated that Resident 59 was now experiencing a significant weight loss of 9 percent in one month. The dietary note indicated to continue the Boost.</p> <p>Interview with Employee 13, medical records and purchasing, on June 13, 2024, at 11:14 AM confirmed that the facility does not always receive the supply of Boost that is initially ordered.</p> <p>Interview with the Administrator and Director of Nursing on June 13, 2024, at 2:00 PM acknowledged the above findings for Residents 25 and 59.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>19719</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide the coordination of dialysis services and administration of physician ordered medications for one of one resident reviewed (Resident 28).</p> <p>Findings include:</p> <p>Review of Resident 28's clinical record revealed that she received kidney dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) on Tuesdays, Thursdays, and Saturdays at an outside provider. Resident 28 leaves the facility to go to dialysis prior to breakfast being served around 6:45 AM.</p> <p>Review of Resident 28's current physician orders revealed that nursing staff are to administer the following medications in the morning:</p> <p>Miralax (stool softener) 17 grams, one scoop at 8:00 AM</p> <p>Protonix (treats acid reflux) 40 mg (milligrams) at 8:00 AM</p> <p>Eliquis (a blood thinner) 2.5 mg at 8:00 AM</p> <p>Simethicone (relives symptoms of extra gas) 125 mg at 7:00 AM</p> <p>Review of Resident 28's Medication Administration Record (MAR, a form utilized to document the administration of medications) dated June 2024, revealed that there were several days when nursing staff did not administer the above medications in the morning due to Resident 28 being at dialysis. There was no documented evidence in Resident 28's clinical record to indicate that the facility coordinated care with dialysis or her physician to determine if the medications were to be given at a different time or if they were appropriate to be skipped on dialysis days.</p> <p>Interview with the Director of Nursing on June 14, 2024, at 10:30 AM confirmed the above findings for Resident 28.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738</p> <p>Based on review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to properly assess and obtain informed consent or provide the resident and/or responsible party with the risks and benefits for the use of side rails for two of 11 residents reviewed (Residents 10 and 34).</p> <p>Findings include:</p> <p>The policy entitled Use of Bed Rails, last reviewed without changes on August 1, 2023, revealed the purpose of the guidelines is to ensure the safe use of bed rails as resident mobility aids and to prohibit the use of bed rails as restraints unless necessary to treat a resident's medical symptoms.</p> <p>Further review of the policy included a section titled, General Guidelines, which noted that an assessment will be made to determine the resident's symptoms, risk of entrapment, and reason for using the bed rails. When used for mobility or transfer, an assessment will include review of the resident's bed mobility, ability to change positions, transfer to and from bed or chair, to stand and toilet, potential risks with the use of bed rails, and that the bed's dimensions are appropriate for the resident's size and weight. The policy noted that consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol. When bed rail use is appropriate, the facility will assess the space between the mattress and bed rails to reduce the risk of entrapment (the amount of space may vary depending on the type of bed and mattress being used).</p> <p>Observation of Resident 10 on June 11, 2024, at 12:58 PM revealed the resident's bed had a right sided enabler bar (halo type) on it. The other side of the bed was against the wall and did not have an observed enabler bar or side rail.</p> <p>Observation of Resident 10 on June 14, 2024, at 10:30 AM revealed the resident was in bed. The enabler bar was again noted on the resident's right side of the bed. The other side of the bed remained against the wall.</p> <p>Clinical record review for Resident 10 revealed an MDS assessment (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated May 2, 2024, that revealed the resident had severely impaired cognitive skills with a BIMS (Brief Interview for Mental Status) score of two indicating severe cognitive impairment.</p> <p>The current care plan for Resident 10 revealed the resident had an activities of daily living (ADL) self-care performance deficit related to a history of a cerebrovascular accident (CVA, stroke). An intervention noted the resident required one staff to reposition and turn in bed for bed mobility.</p> <p>Facility documentation titled, Communication Memo, for Resident 10 and dated March 20, 2023, revealed the resident needs bed rails and had a written B circled indicating bilateral bed rails. A handwritten notation indicated Done 3/21/23. The room for Resident 10 was a different room than the current room the resident was observed in by the surveyor.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Bed Rail Evaluation dated March 21, 2023, revealed the resident had the following checked under recommendations: Bed rails or grab bars are indicated and serve as an enabler to promote independence with bed mobility and positioning.</p> <p>Facility documentation titled, Bed System Measurement Device Test Results Worksheet, dated March 21, 2023, noted a Bed ID of 69. The bed make was written as DS Panacea and a model 1500. Entrapment zones were assessed for bilateral bed rails per the documentation.</p> <p>An interview with Employee 10, Maintenance Director, on June 14, 2024, at 10:48 AM revealed that maintenance usually installs the bed rails and assesses the entrapment zones with a device they have. Employee 10 confirmed the document for Resident 10 titled, Bed System Measurement Device Test Results Worksheet, indicated that bilateral bed rails were assessed.</p> <p>Observation of Resident 10's bed with Employee 10 on June 14, 2024, at 10:52 AM revealed that the current bed is different than what was assessed on the documentation provided by the facility. The resident was currently in a Hill-Rom bed, which is a different bed than what was originally assessed. The enabler bars are also different than what was originally assessed per Employee 10. Employee 10 further noted there was no maintenance order to reassess the bed when the resident changed rooms.</p> <p>A review of the census documentation for Resident 10 revealed the resident was admitted to the facility on [DATE]. The census indicated the resident changed rooms on April 10, 2023, June 22, 2023, March 14, 2024, and April 28, 2024, (where the resident currently resides).</p> <p>Further clinical record review revealed no documentation that Resident 10's enabler bar(s) and bed was reassessed or transferred with the resident to the different rooms. There was also no evidence of any type of informed consent explaining the risks and benefits of the enabler bar(s). The facility could provide no further documentation regarding Resident 10's enabler bar.</p> <p>An interview on June 14, 2024, at 11:07 AM revealed that the Nursing Home Administrator was aware of the above information for Resident 10. Further interview on June 14, 2024, at 12:58 PM with the Nursing Home Administrator and Employee 6, registered nurse clinical consultant, revealed there was no further evidence to indicate that the resident or responsible party was informed of the risks and benefits of enabler bars.</p> <p>Observation of Resident 34's room on June 11, 2024, at 2:04 PM revealed assistive devices mounted bilaterally to Resident 34's bed.</p> <p>The surveyor requested documentation regarding Resident 34's assessed need for assistive devices on her bed, consent for their use, and assessments pertaining to entrapment risks during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 6 (clinical consultant) on June 12, 2024, at 2:00 PM.</p> <p>Clinical record review for Resident 34 revealed occupational therapy documentation dated August 24, 2022, that Resident 34 had enabler (Halo) bars installed and tested on the right side of her bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Bed System Measurement Device Test Results Worksheet dated August 25, 2022, indicated that potential zones of entrapment were evaluated on the right side of Resident 34's bed. There were no zones assessed on the left side of Resident 34's bed. Handwritten documentation on this form that were undated and unsigned noted that Resident 34 moved rooms twice and had an, R, and an, L, circled.</p> <p>Resident 34's clinical record contained no evidence that the facility completed a bed rail evaluation since August 22, 2022, even though Resident 34 moved to a different room twice and the intervention was revised from one side to bilaterally. The facility did not provide evidence that Resident 34 or her responsible party signed a consent for the use of the enabler devices.</p> <p>The surveyor confirmed the above concerns regarding Resident 34's assistive devices during an interview with the Nursing Home Administrator, the Director of Nursing, and Employee 6 on June 13, 2024.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>19719</p> <p>Based on staff interview, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to wound care (Employees 1 and 2).</p> <p>Findings include:</p> <p>A review of the facility's current resident population documentation revealed that the facility had four residents who had skin concerns and/or wounds.</p> <p>A request for nursing staff competencies for wound care revealed the facility was unable to provide any. Interview with Employee 6, clinical consultant, on June 14, 2024, at 12:15 PM revealed that the facility does not have any competencies on Employee 1 or Employee 2 (both licensed practical nurses).</p> <p>The findings were reviewed with the Administrator and Director of Nursing on June 14, 2024, at 12:30 PM.</p> <p>28 Pa Code 201.20(a) Staff development</p>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>19719</p> <p>Based on review of active nurse aides and staff interview, it was determined that the facility failed to complete a performance evaluation of every nurse aide at least once every 12 months for three of three nurse aides reviewed (Employees 3, 4, and 5).</p> <p>Findings Include:</p> <p>Review of the facility's list of active nurse aide staff revealed Employee 3 with a hire date in 2022; Employee 4 with hire date in 2022; and Employee 5 with a hire date in 2022.</p> <p>Requests to review Employees 3, 4, and 5's performance evaluations revealed no documented evidence that the facility is completing the evaluations at least once every 12 months.</p> <p>Interview with Employee 6, clinical consultant, on June 14, 2024, at 12:13 PM confirmed the above findings and indicated that no performance evaluations can be provided on any current nurse aide working in the facility.</p> <p>28 Pa. Code 201.19 Personnel policies and procedures</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>44738</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident's attending physician addressed pharmacy recommendations for four of five residents reviewed (Residents 10, 22, 25, and 46).</p> <p>Findings include:</p> <p>Review of Resident 10's clinical record revealed that the pharmacist made recommendations on the following dates: February 25, 2024, and November 20, 2023. There was no documented evidence in Resident 10's clinical record to indicate what the recommendations were and if the recommendations were acted upon. Interview with the Director of Nursing (DON) on June 14, 2024, at 12:00 PM confirmed the recommendations could not be located for Resident 10.</p> <p>Review of Resident 46's clinical record revealed that the pharmacist made recommendations on the following dates: March 28, 2024, February 25, 2024, January 28, 2024, November 20, 2023, and September 22, 2023. There was no documented evidence in Resident 46's clinical record to indicate what the recommendations were or if the recommendations were acted upon. Interview with the DON on June 14, 2024, at 12:00 PM confirmed the recommendations could not be located for Resident 46.</p> <p>Review of Resident 25's clinical record revealed that the pharmacist made recommendation on the following dates: October 16, 2023, December 19, 2023, and March 28, 2024. There was no documented evidence in Resident 25's clinical record to indicate what the recommendations were or if the recommendations were acted upon.</p> <p>Interview with the Administrator on June 14, 2024, at 9:46 AM confirmed the above findings for Resident 25.</p> <p>Clinical record review for Resident 22 revealed documentation by the consultant pharmacist dated May 26, 2024, that indicated recommendations were made and to, review Clinical Pharmacy Report.</p> <p>Resident 22's clinical record did not contain a Clinical Pharmacy Report, or documentation as to the details of the recommendation or if a physician acted upon the recommendation.</p> <p>The surveyor requested any additional information available to resolve the above concern for Resident 22 during an interview with the Nursing Home Administrator, the Director of Nursing, and Employee 6, on June 13, 2024, at 2:22 PM; however, the facility did not provide any additional information during the onsite survey.</p> <p>483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On</p> <p>Previously cited deficiency 7/21/23</p> <p>28 Pa. Code 211.9 (d)(k) Pharmacy services</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>

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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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44738</p> <p>Based on observation and staff interview, it was determined that the facility failed to store food items and maintain equipment in a safe and sanitary manner in the facility's main kitchen.</p> <p>Findings included:</p> <p>Initial tour of the facility's main kitchen on June 11, 2024, between 10:25 AM and 11:07 AM revealed the following:</p> <p>The clear lights on the ceiling had multiple dead insects and debris accumulated in the protective covers.</p> <p>There were opened bread products on a plastic rack near the kitchen entrance with no open dates that included the following: a partially used bag of hamburger buns, an open bag of hot dog buns, and a partially used loaf of bread.</p> <p>A wire storage rack in front of the sink had a build-up of debris on the bottom protective cover/shelf.</p> <p>There was a significant build-up of debris at the perimeter of the kitchen where the floor meets the wall.</p> <p>There was an extensive build-up of dust inside of the steamer exhaust area.</p> <p>A second wire storage rack had debris accumulating on the bottom cover/shelf.</p> <p>A clear plastic container holding various green and red lids that Employee 12, Dietary Manager, identified as clean had a dead insect in the bottom of the container.</p> <p>A plastic base of a stainless-steel coffee container was broken and cracked.</p> <p>A container of handled plastic adaptive cups and various other plastic cups were stained and there was debris in the bottom of the plastic container the cups were being stored in.</p> <p>There were 16 bowls of various cereals that were uncovered with no noted labels or dates.</p> <p>There were two slices of bread wrapped in saranwrap on the stainless-steel shelf above the steam table that were not labeled or dated.</p> <p>There were nine clear, small plastic containers of a brown sugar like substance with no labels or dates on them on the stainless-steel shelf above the steam table.</p> <p>The underside of the stainless-steel shelf above the steam table had an accumulation of debris.</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 - Many</p>	<p>There was a significant accumulation of dust on top of the commercial coffee machine.</p> <p>Three frying pans of various sizes hanging from a rack near the middle of the kitchen had an extensive build-up of a black color, that appeared to be burnt on the cooking surface of the pans.</p> <p>Multiple clear plastic containers that were stored and stacked upside down on a shelf had an extensive volume of moisture between the containers.</p> <p>There were significant splash stains that were brown in color on the wall near the fire extinguisher.</p> <p>There was a container of Italian dressing with no open date in a refrigerator near the main entrance to the kitchen.</p> <p>There were eight cups of a milk like liquid, five cups that appeared to be orange juice, and a sealed Yoplait original container with no labels or dates in a refrigerator located near the fire extinguisher. The milk like liquid was spilled in the bottom of the container.</p> <p>There were 15 lidded plastic cups of fruit being stored in the refrigerator located near the fire extinguisher. Seven of the containers had dislodged lids which left the fruit open to the air.</p> <p>There was a large, lidded container of sliced American cheese in the refrigerator near the fire extinguisher. There were no labels or dates on the container.</p> <p>There were six pies with no labels or dates located in the refrigerator near the fire extinguisher.</p> <p>The roll-up door at the loading dock had an extensive build-up of cobwebs around the door.</p> <p>The light on the ceiling at the loading dock had a build-up of debris and dead insects on the exterior of it.</p> <p>The alcohol-based hand cleaner dispenser at the loading dock had a significant build-up of black-colored dust on it.</p> <p>The walk-in freezer had an extensive build-up of ice on multiple food items that included various sealed meats and boxes. There was a layer of ice on the interior ceiling of the freezer especially near the cooling fans. There were multiple icicles hanging from a black conduit pipe under the cooling fans. A concurrent interview with Employee 12 revealed the door to the freezer was bowed and this causes a bad ice build-up. Employee 12 further reported that maintenance uses a heat gun twice a week to help dethaw the freezer.</p> <p>There was a build-up of cobwebs on the ceiling at the entrance from the loading dock area to the main kitchen.</p> <p>There were extensive brown stains on the ceiling above the dishwasher area and there were areas of a black colored stains where the wall meets the ceiling above the dishwasher.</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 - Many</p>	<p>The above findings were reviewed with Employee 12 on June 11, 2024, at 11:35 AM and the Nursing Home Administrator and Director of Nursing on June 13, 2024, at 2:15 PM.</p> <p>A review of the Refrigerator/Freezer Temperature Log for June 2024, for the refrigerator located as by door, revealed a notation that indicated, Refrigerator temperatures below 40 degrees. Review of the temperatures for Night Shift revealed the following dates where temperatures were above the desired 40 degrees: June 6, 2024, at 42 degrees; June 7, 2024, at 42 degrees; and June 10, 2024, at 46 degrees. There was no documented corrective action or recheck of the temperature documented on the form in the Corrective Action section for these dates.</p> <p>The above information regarding the temperature log was reviewed with the Nursing Home Administrator on June 14, 2024, at 1:14 PM.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>44738</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure accurate clinical documentation for two of 13 residents reviewed (Residents 20 and 50).</p> <p>Findings include:</p> <p>Clinical record review for Resident 20 revealed that the resident was discharged from hospice services on March 17, 2023.</p> <p>Clinical documentation for Resident 20 dated May 16, 2024, at 2:21 PM revealed a physician's progress note that indicated under the notes section titled Care Plan to Continue Hospice care. Under the section titled Counseling and/or Coordination of Care of the same note it indicated to Continue skilled level of care.</p> <p>Clinical documentation for Resident 20 dated May 9, 2024, at 2:20 PM revealed a physician's progress note that indicated under the notes section titled Care Plan to Continue Hospice care. Under the section titled Counseling and/or Coordination of Care of the same note it indicated to Continue skilled level of nursing.</p> <p>Clinical documentation for Resident 20 dated April 4, 2024, at 2:06 PM revealed a physician's progress note that indicated under the notes section titled Subjective the, Patient will continue with Hospice care. Under the section titled Care Plan the documentation noted that, Patient is on Hospice will continue current Tx (treatment).</p> <p>Clinical documentation for Resident 20 dated March 21, 2023, at 4:56 PM revealed a physician's progress note that indicated under the notes section titled Subjective the, Patient will continue with Hospice care. Under the note section titled Care Plan to Continue Hospice care. Under Assessment four of the note, the documentation noted, Patient is on hospice and will continue current Tx (treatment).</p> <p>An interview with the Nursing Home Administrator and Director of Nursing on June 13, 2024, at 2:15 PM confirmed the resident was discharged from hospice services on March 17, 2023. It was unclear why the above documentation for Resident 20 continued to mention hospice care, but believed it was related to documentation errors.</p> <p>Clinical record review for Resident 50 revealed that the resident was on Gabapentin (a medication that can be used to treat seizures and nerve pain) oral capsule and give 300 milligrams (mg) by mouth three times a day for neuropathy (pain caused by nerve damage). This order was discontinued on May 1, 2024.</p> <p>A review of the census information for Resident 50 revealed the resident was hospitalized from April 30, 2024, to May 7, 2024.</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 - Some</p>	<p>A Discharge Summary for Resident 50 from the hospital revealed a discharge medication list that did not include gabapentin. The gabapentin was not reordered by the facility upon return from the hospital and was not listed under the current orders for Resident 50.</p> <p>Clinical documentation for Resident 50 revealed a Nurse Practitioner Progress Note dated May 30, 2024, at 3:29 PM that indicated an assessment and plan that noted pain and to continue with Tylenol (a medication used to treat pain and fever), lidocaine patch (a transdermal patch that goes on the skin that contains a medication used to treat pain), and gabapentin 300 mg by mouth three times a day as ordered.</p> <p>Clinical documentation for Resident 50 revealed a Nurse Practitioner Progress Note dated June 6, 2024, at 5:03 PM that indicated an assessment and plan that noted pain and to discontinue the lidocaine patch five percent, start Aspercreme patch (a transdermal patch used to treat pain), continue Tylenol, and gabapentin 300 mg by mouth three times a day as ordered.</p> <p>The above information for Resident 50 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 13, 2024, at 2:15 PM.</p> <p>An interview with the Director of Nursing on June 14, 2024, at 10:14 AM confirmed that the gabapentin was discontinued on May 1, 2024, by the physician and there was not a current order to administer it. It was believed that the above documentation for Resident 50 was a documentation error since there were no current orders entered in the electronic medical record to administer the gabapentin.</p> <p>28 Pa. Code 211.5(i) Medical records</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0848</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>20725</p> <p>Provide a neutral and fair arbitration process and agree to arbitrator and venue.</p> <p>Based on review of the facility's arbitration agreements and staff interview, it was determined that the facility's arbitration agreements failed to ensure a neutral and fair arbitration process by ensuring the selection of a neutral arbitrator for six of six residents reviewed with a signed arbitration agreement (Residents 34, 47, 16, 62, 49, and 26).</p> <p>Findings include:</p> <p>Review of a Mandatory Binding Arbitration Agreement (an agreement that the resident and the facility will resolve legal disputes through binding arbitration, waiving their right to a trial) signed by Resident 34 on August 22, 2022, revealed that the document stipulated that, All Arbitrations shall be administered by (name of arbitrator services company which the facility utilized). The document also stipulated that if, (name of arbitrator services company which the facility utilized), is unable or unwilling to handle the Arbitration, the parties will work in good faith to agree on an alternative neutral arbitration service, and if the parties cannot reach an agreement within thirty (30) days, the Facility will select a neutral arbitrator to resolve the arbitration .</p> <p>The agreement afforded the facility the selection of the arbitrator (third-party decision-maker contracted to resolve a dispute) initially and/or if the parties cannot reach an agreement on a neutral arbitration service within 30 days.</p> <p>Review of a Mandatory Binding Arbitration Agreement signed by Resident 47 on December 29, 2022, revealed that she signed a document with the same verbiage as Resident 34 that afforded the facility the selection of the arbitrator initially and/or if the parties cannot reach an agreement on a neutral arbitration service within 30 days.</p> <p>Review of an Arbitration Agreement signed by Resident 16 on October 14, 2023, revealed that the document stipulated, To start an Arbitration, a party must submit a written request for Arbitration to the other party within the time limit required by this Arbitration Agreement. At that point the parties will work together in good faith to agree upon a neutral arbitrator to resolve the dispute. By signing this Arbitration Agreement, the parties hereby agree that if the parties cannot agree on a neutral arbitrator after thirty (30) days, then (name of arbitrator services company which the facility utilized) will serve as neutral arbitrator .</p> <p>Review of an Arbitration Agreement signed by Resident 62 on June 11, 2024, revealed that she signed a document with the same verbiage as Resident 16 that afforded the facility the selection of the arbitrator if the parties cannot reach an agreement on a neutral arbitration service within 30 days.</p> <p>Resident 49's representative signed this version of an Arbitration Agreement on February 13, 2024. Resident 26's representative signed this version of an Arbitration Agreement on February 9, 2024.</p> <p>Interview with Employee 13 (medical records) on June 13, 2024, at 11:08 AM and 1:17 PM confirmed that all arbitration agreements reviewed for Residents 34, 47, 16, 62, 49, and 26 afford the facility's selection of an arbitrator either initially and/or if the parties cannot reach an agreement on a neutral arbitration service within 30 days.</p> <p>(continued on next page)</p>		

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<p>F 0848</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The surveyor confirmed the above findings pertaining to arbitration agreements for Residents 34, 47, 16, 62, 49, and 26, during an interview with the Nursing Home Administrator, the Director of Nursing, and Employee 6 (clinical consultant), on June 13, 2024, at 2:00 PM.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(2) Management.</p> <p>28 Pa. Code 201.29(a)(j) Resident rights</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>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19719</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to implement appropriate enhanced barrier transmission-based precautions for four of 13 residents reviewed (Residents 25, 49, 59, and 60).</p> <p>Findings include:</p> <p>Review of the memo entitled Enhanced Barrier Precautions (EBP, gown and glove use) in Nursing Homes to Prevent the Spread of Multi-drug Resistant Organisms released by the Center for Medicaid and Medicare Services (CMS) on March 20, 2024, with an implementation date of April 1, 2024, revealed that nursing care facilities are to use EBP for residents with chronic wounds or indwelling medical devices (i.e., indwelling urinary catheters) during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care.</p> <p>Interview with Employee 5, nurse aide, on June 12, 2024, at 11:18 AM revealed that the nurses usually tell the aides if someone is using EBP and if there was PPE (personal protective equipment, such as gloves, masks, and gowns) hanging on the door. Employee 5 indicated that if they are not told or if no PPE is on the door, they would have no idea if a resident was on EBP or not.</p> <p>Review of Resident 25's clinical record revealed a Minimum Data Set Assessment (MDS, an assessment tool completed at specific intervals to determine care needs) dated May 28, 2024, that indicated the facility assessed Resident 25 as using an indwelling urinary catheter. There was no documented evidence in Resident 25's clinical record to indicate that the facility implemented the use of EBP. Observation of Resident 25's room on June 12, 2024, at 11:21 AM revealed no evidence that nursing staff were to use EBP when performing high-contact activity for Resident 25, such as signage or PPE.</p> <p>Review of Resident 49's clinical record revealed an MDS dated [DATE], that indicated the facility assessed Resident 49 as using an indwelling urinary catheter. There was no documented evidence in Resident 49's clinical record to indicate that the facility implemented the use of EBP. Observation of Resident 49's room on June 12, 2024, at 11:23 AM revealed no evidence that nursing staff were using EBP when performing high-contact activity for Resident 49, such as signage or PPE.</p> <p>Review of Resident 59's clinical record revealed an MDS dated [DATE], that indicated the facility assessed her as having a current unstageable pressure ulcer to her bottom. A skin assessment dated [DATE], indicated that the wound consultant assessed Resident 59's wound as being a Stage 4 (full thickness skin loss exposing muscle, bone, or tendon). There was no documented evidence in Resident 59's clinical record to indicate that the facility implemented the use of EBP. Observation of Resident 59's room on June 12, 2024, at 11:25 AM revealed no evidence that nursing staff were using EBP when performing high-contact activity for Resident 59, such as signage or PPE.</p> <p>Interview with the Administrator and Director of Nursing on June 12, 2024, at 2:07 PM confirmed the above findings for Residents 25, 49 and 59, and indicated that EBP should have been implemented.</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>Observation of Resident 60 with Employee 14 (licensed practical nurse) on June 11, 2024, at 1:43 PM revealed she was in bed with an indwelling urinary catheter collection bag stored directly on the floor on the left side of her bed. A dignity bag (material bag used to hold and obscure the urinary collection bag that may keep the surface of the bag from potentially infectious surfaces) that was secured to the right side of her bed was empty. A yellow PPE organizer was hung from Resident 60's room door. Interview with Employee 14, on the date and time of the observation, indicated that Resident 60 required EBP due to an indwelling urinary catheter and a pressure ulcer. Employee 14 confirmed that Resident 60's room did not have bins to discard PPE (e.g., gowns or linens, etc.) before leaving Resident 60's room.</p> <p>Observation of Resident 60 on June 12, 2024, at 12:38 PM with Employee 14 and Employee 15 (nurse aide) revealed staff stored the urinary collection bag directly on the floor on the left side of the bed. The dignity bag also secured to the left side of Resident 60's bed was empty. Employee 15 repositioned the urinary collection bag to inside the dignity bag.</p> <p>The surveyor reviewed the above infection control concerns for Resident 60 with the Director of Nursing on June 14, 2024, at 10:30 AM.</p> <p>28 Pa. Code 201.18(b)(3)(d)(e)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>20725</p> <p>Based on staff interview and a review of the facility's infection control program, it was determined that the facility failed to have a designated Infection Preventionist with the necessary qualifications responsible for the facility's infection prevention and control program.</p> <p>Findings include:</p> <p>Interview with the Nursing Home Administrator on June 11, 2024, at 10:02 AM revealed that the facility's previous Director of Nursing from April 1, 2024, to June 2, 2024, fulfilled the position of infection preventionist until her discontinuation of employment on June 2, 2024. The interview indicated that a current licensed practical nurse employee assumed the infection preventionist position.</p> <p>Interview with the Nursing Home Administrator on June 13, 2024, at 10:04 AM confirmed that no staff currently employed by the facility has completed any specialized training in infection prevention and control. The interview also confirmed that the facility could not provide any evidence of infection control committee meetings (that included the required members) since the facility's last standard survey that ended on July 21, 2023.</p> <p>Interview with the Director of Nursing on June 14, 2024, at 10:30 AM indicated that she has not completed any specialized training in infection prevention and control; however, she has attempted to monitor antibiotic use and infection prevalence in the facility. The interview indicated that she could not provide a current line listing of the facility's infections or evidence of antibiotic surveillance that she has completed. The Director of Nursing also confirmed that she did not have access to the State's PA-PSRS (Pennsylvania Patient Safety Reporting System, a secure, web-based, system that permits healthcare facilities to submit reports that are defined as serious events and incidents) reporting system; she did not know who was performing that task.</p> <p>Interview with the Director of Nursing, the Nursing Home Administrator, and Employee 6 (clinical consultant) on June 14, 2024, at 11:45 AM confirmed the above findings regarding the infection preventionist position.</p> <p>28 Pa. Code 201.18(b)(1)e)(1)(3)(6) Management</p> <p>28 Pa. Code 201.19(3) Personnel policies and procedures</p> <p>28 Pa. Code 211.12(c)(d)(1)(4)(5) Nursing services</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725</p> <p>Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to offer the COVID-19 vaccine as indicated by the Centers for Disease Control (CDC) for four of five residents reviewed for immunization concerns (Residents 2, 35, 36, and 60).</p> <p>Findings include:</p> <p>The facility policy entitled, Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures, last reviewed without changes on August 1, 2023, revealed that the infection prevention and control measures that are implemented to address the SARS-Co V-2 are incorporated into the facility infection prevention and control plan. These measures include encouraging staff, residents, and visitors, to remain up to date with all COVID-19 vaccine doses.</p> <p>The policy provided by the facility did not include education provided to residents regarding benefits and potential risks associated with the COVID-19 vaccine, or the documentation maintained regarding education provided, administration of vaccines, or recommendations implemented per the CDC.</p> <p>Current CDC guidelines at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html recommend that people aged [AGE] years and older who received one dose of any updated 2023-2024 COVID-19 vaccine (Pfizer-BioNTech, Moderna, or Novavax) should receive one additional dose of an updated COVID-19 vaccine at least four months after the previous updated dose. People aged [AGE] years and older are up to date when they have received two updated 2023-2024 COVID-19 vaccine doses. People aged [AGE] years and older who have not previously received any COVID-19 vaccine doses and choose to get Novavax should get two doses of updated Novavax vaccine, followed by one additional dose of any updated 2023-2024 COVID-19 vaccine to be up to date.</p> <p>Clinical record review for Resident 2 revealed that the facility admitted her on December 3, 2021; and that she was [AGE] years old. Review of immunization information contained in her medical record revealed that her last COVID-19 immunization was on August 2, 2022. There was no evidence that the facility provided vaccine information or offered any 2023-2024, or Novavax COVID-19 immunizations to Resident 2 after 2022.</p> <p>Clinical record review for Resident 35 revealed that the facility admitted her on July 31, 2020; and that she was [AGE] years old. Review of immunization information contained in her medical record revealed that her last COVID-19 immunization was on June 24, 2022. There was no evidence that the facility provided vaccine information or offered any 2023-2024, or Novavax COVID-19 immunizations to Resident 35 after 2022.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Athens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 South Main St Athens, PA 18810	
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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Clinical record review for Resident 36 revealed that the facility admitted her on December 16, 2022, and that she was [AGE] years old. Review of immunization information contained in her medical record revealed that her last COVID-19 immunization was on December 8, 2021. There was no evidence that the facility provided vaccine information or offered any 2023-2024, or Novavax COVID-19 immunizations to Resident 36 after 2021.</p> <p>Clinical record review for Resident 60 revealed that the facility admitted her on December 30, 2023, and that she was [AGE] years old. Review of immunization information contained in her medical record revealed that her last COVID-19 immunization was on June 9, 2021. There was no evidence that the facility provided vaccine information or offered any 2023-2024, or Novavax COVID-19 immunizations to Resident 60.</p> <p>Interview with the Director of Nursing on June 14, 2024, at 10:30 AM requested any additional evidence regarding the COVID-19 immunizations for Residents 2, 35, 36, and 60.</p> <p>Interview with the Director of Nursing, the Nursing Home Administrator, and Employee 6 (clinical consultant) on June 14, 2024, at 11:45 AM confirmed that the facility had no additional information to evidence that Residents 2, 35, 36, and 60 were provided education regarding COVID 19 immunizations, or an immunization to remain up to date with the available COVID-19 vaccines.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa. Code 211.10(a)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>44738</p> <p>Based on observation and staff interview, it was determined that the facility failed to ensure that essential equipment was in safe operating condition for the facility's main kitchen.</p> <p>Findings include:</p> <p>Observation and concurrent interview with Employee 12, Dietary Manager, of the walk-in freezer on June 11, 2024, at 11:00 AM revealed the emergency release on the interior of the freezer was broken and introduced an entrapment risk if the door would close and lock with a staff member inside of the freezer. It was unknown how long the emergency release was not functional. Employee 12 further noted that two staff members are supposed to be present when using the walk-in freezer so one staff member can stay outside to prevent the door from fully closing. Employee 12 indicated that maintenance is aware of the issue, but it has not been fixed.</p> <p>The Nursing Home Administrator was made aware of the issue on June 11, 2024, at 12:17 PM and again at 2:00 PM.</p> <p>The above was also reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 13, 2024, at 2:15 PM.</p> <p>28 Pa. Code 207.2(a) Administrator's responsibility</p>		