

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396143	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER Aristacare at East Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 Henry Avenue, 7th Floor Philadelphia, PA 19129	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48347</p> <p>Based on observation and interviews with residents and staff, it was determined that the facility failed to maintain or enhance the dignity and respect related to dining for one of one nursing unit. (Nursing Unit rooms 701-738)</p> <p>Findings include:</p> <p>Observation on October 1, 2024, at 12:00 p.m. revealed lunch carts delivered to the nursing unit (rooms 701-738) and then lunch delivered to residents in their rooms. The lunch trays were observed as being served on Styrofoam plates and plastic utensils.</p> <p>Observation on October 2, 2024, at 12:10 p.m. revealed lunch carts delivered to the nursing unit (rooms 701-738) and then delivered to the residents in their rooms. The lunch trays were observed as being served on Styrofoam plates and plastic utensils.</p> <p>Interview with resident R21 on October 2, 2024, at 12:25p.m. revealed that he sometimes receives plastic utensils and sometimes receives regular utensils and he would prefer regular dinnerware, the plastic is difficult to use.</p> <p>Interview with Employee E12, Registered Dietician, on October 2, 2024, at 01:30 p.m. revealed that she was unaware that the residents were receiving disposable plates and utensils.</p> <p>Continued interview with Employee E12 on October 3, 2024 at 11:22a.m. during second tour of the kitchen, the lunch meal was observed prepped and plated on disposable plates. Employee E12 confirmed the observation and responded that the number of residents receiving lunch has grown and the facility has not adjusted the stock of dinnerware to accommodate the additional residents.</p> <p>Observation of employee E 20 on October 3, 2024, at 11:50 a.m. revealed the employee plated the resident's lunch meal onto Styrofoam plates and plastic utensils. Interview with Employee E20 on October 3, 2024, at approximately 11:25 a.m. revealed they only have 7 or 8 dishes and not enough utensils for the residents. Employee E20 revealed that they have not had dishes or silverware since the Covid epidemic and that the kitchen manager has ordered dishes and silver utensils are on order. As of this time of interview the utensils have been delivered, staff still waiting for plates.</p> <p>28 Pa. Code 201.18 (b)(1) Management</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 201.29 (j)Resident rights</p>		

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<p>F 0563</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 receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>48347</p> <p>Based on interviews with resident and staff, review of facility policy, and staff interview, it was determined that the facility failed to ensure that visitors were able to visit residents at all times for one of one resident reviewed. (Resident R203)</p> <p>Findings include:</p> <p>Review a facility policy titled Visitation revealed that the facility permits residents to receive visitors subject to the residents wishes and the protection of the rights of other residents in the facility. The resident's immediate family or other relatives may visit the resident at any time subject to the protection of the rights and safety of other residents. The visiting hours for non-family members are from 10:00 a.m. to 7:30p.m. daily or as designated by the administrator.</p> <p>CMS issued guidance to the previously released QSO-NH-20-39 issued on September 17, 2020, and revised on November 12, 2021, regarding visitation in nursing homes. This revised guidance stated that Visitation is now allowed for all residents at all times This was to be imposed immediately by nursing home facilities.</p> <p>Review of resident's clinical record revealed that the Resident R203 was admitted with diagnosis of acute and chronic respiratory failure (Respiratory failure happens when not enough oxygen passes from your lungs to your blood), Type 2 diabetes (a condition in which your body does not use insulin well and cannot keep blood sugar at normal levels), psychoactive substance abuse (psychoactive substances include the alcohol caffeine nicotine marijuana and certain pain medications many illegal drugs such as harrowing cocaine amphetamines are also psychoactive substance, sepsis (a condition in which the body responds improperly to an infection), heart failure, hypertension (high blood pressure) asthma, abnormalities of gate (a walking abnormal when a person is unable to walk normally due to injuries underlining conditions or issues relating with legs and feet mobility) and malnutrition.</p> <p>Interview conducated on October 1, 2024, at 10:45 a.m.with resident R203's fiancee was observed as being visibly upset, stated that she was asked to leave on a previous evening. This visitor stated she was not bothering anyone or disturbing anyone, she just wanted to be with the resident.</p> <p>Review of facility resident clinical record nursing notes revealed that the facility requested resident R 203's significant other to leave after visiting hours.</p> <p>Interview with Nursing Home Administrator Employee E1, and Director of nursing, Employee E 2, on October 3, 2024, at 8:42a.m. revealed that that Resident R203's visitor is not family therefore and may only visit during visiting hours. The visitor was asked to leave because she was asleep in the resident guest chair and resident has a roommate that has the rights of privacy. Employee E1 also revealed that she and the staff have concerns regarding this visitor and the safety of Resident R203. At the time of interview Employee E 1 and Employee E 2, were contacting Resident R203's visitor to set up supervised visits.</p> <p>28 Pa. Code 201. 18 (b)(1) (2) Management</p> <p>(continued on next page)</p>		

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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 201. 29 (c) Resident rights</p> <p>28 Pa. Code 211. 10 (a) Resident care policy</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on observation, clinical record review, and review of facility policy and staff interview, it was determined that the facility did not ensure that the resident's privacy, regarding medical records were protected for one of seven residents observed. (Resident R13)</p> <p>Findings include:</p> <p>Policy title Uses and Disclosures of Protected Health Information dated August 2024 revealed that the purpose of this policy is to ensure building uses and disclosures of protected health information are in compliance with applicable law and appropriate safeguards are in place to ensure the confidentiality of the client protected health information (PHI). Staff are to minimize all areas where residents' names may be seen with their health information such as a turn paper over with names on it or clues or minimized screen with residents names on them.</p> <p>Review of the United States Department of Health and Human Services Health Insurance Portability and Accountability Act, https://www.hhs.gov/hipaa/for-professionals, revealed The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information.1 To fulfill this requirement, HHS published what are commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The Privacy Rule, or Standards for Privacy of Individually Identifiable Health Information, establishes national standards for the protection of certain health information. The Security Standards for the Protection of Electronic Protected Health Information (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form. The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that organizations called covered entities must put in place to secure individuals' electronic protected health information (e-PHI). Within HHS, the Office for Civil Rights (OCR) has responsibility for enforcing the Privacy and Security Rules with voluntary compliance activities and civil money penalties.</p> <p>For internal uses, a covered entity must develop and implement policies and procedures that restrict access and uses of protected health information based on the specific roles of the members of their workforce. These policies and procedures must identify the persons, or classes of persons, in the workforce who need access to protected health information to carry out their duties, the categories of protected health information to which access is needed, and any conditions under which they need the information to do their jobs.</p> <p>Observation in nursing unit corridor outside of room [ROOM NUMBER] on October 2, 2024, at 9:17 a.m. revealed a computer with the screen open to Resident R13's clinical record.</p> <p>Interview with Infection Preventionist, Employee E27, October 2, 2024, at 9:25 a.m. on the nursing corridor outside room [ROOM NUMBER] revealed that the computer was assigned to Licensed nurse, Employee E11 and confirmed that the computer was not supposed to be left open to the resident's private information.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of Licensed nurse, Employee E11 on October 2, 2024, at 9:31 a.m. on nursing corridor outside room [ROOM NUMBER] revealed the employee walked by and refused to be interviewed by surveyor.</p> <p>28 Pa. Code 211.29(j) Resident Rights</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on observations, clinical record reviews and interviews with staff, it was determined that the facility failed to obtain consent, assess, monitor and re-evaluate hand mitts for one of two residents reviewed for restraints (Resident R150).</p> <p>Findings include:</p> <p>Observation, on October 1, 2024, at 10:46 a.m. revealed that Resident R150 was in bed, restless, and had a hand mitt (device that restricts the hands from being able to grab or hold) on her right hand. Interview, at the time of the observation, Employee E7, licensed nurse, revealed that Resident R150 required the use of hand mitts due to pulling at her tracheostomy and ventilator tubing.</p> <p>Continued observation, on October 1, 2024, at 1:53 p.m. revealed that Resident R150 was asleep comfortably in bed and had hand mitts on both of her hands.</p> <p>Continued observation, on October 2, 2024, at 10:29 a.m. revealed that Resident R150 was asleep comfortably in bed and had hand mitts on both of her hands.</p> <p>Continued observation, on October 3, 2024, at 9:10 a.m. revealed that Resident R150 was asleep comfortably in bed and had hand mitts on both of her hands.</p> <p>Further observation, on October 4, 2024, at 8:40 a.m. revealed that Resident R150 was asleep comfortably in bed and had a hand mitt on her right hand.</p> <p>Review of Resident R150's care plan revealed that she was admitted to the facility on [DATE], and had diagnoses including respiratory failure (not enough oxygen passes from your lungs to your blood), dependence on ventilator (machines that act as bellows to move air in and out of the lungs), tracheostomy (a surgically created hole in your trachea that allows for breathing) and anoxic brain damage (brain damage caused by lack of oxygen to the brain).</p> <p>Continued review of Resident R150's care plan revealed a focus area, dated initiated September 23, 2024, for hand mitts to right and left hands due to tracheostomy pulling, remove and assess every two hours. Interventions included to assess quarterly and as needed for least restrictive restraint; communicate with physician original need and further evaluations, educate resident and/or family about the risks, benefits and alternatives tried prior to current restraint; inform resident/surrogate about the use of restraints; and release restraints every two hours and provide exercises and/or repositioning.</p> <p>Review of physician orders for Resident R150 revealed an order, dated September 23, 2024, for safety device: hand mitts. The order indicated to use the mitts as needed due to pulling at tracheostomy tube.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of progress notes for Resident R150 revealed a nurses note, dated September 23, 2024, at 6:44 p. m. which stated, New order for hand mitts due to patient pulling at trach [tracheostomy] tube. MD order. Removed Q2h [every two hours].</p> <p>Continued review of progress notes for Resident R150 revealed a physicians note, dated September 26, 2024, at 5:15 p.m. which stated, Attempting to remove vent [ventilator] at times per note review, monitor redirect reorient.</p> <p>Continued review of progress notes for Resident R150 revealed a physicians note, dated September 27, 2024, at 10:21 a.m. which stated, Attempting to remove vent [ventilator] at times per note review, monitor redirect reorient, mits in place.</p> <p>Continued review of progress notes for Resident R150 revealed a respiratory therapy note, dated October 1, 2024, at 1:22 a.m. which stated, Pt [patient] disconnected vent [ventilator] circuit x 2. Hand mitts is on to prevent it.</p> <p>Further review of Resident R150's clinical record revealed that there was no assessment completed to ensure that the least restrictive devices were used, no indication for length of time for restraint use, no indication of re-evaluation for continued use of restraints, no indication that the resident's family was informed, educated or gave consent for the use of restraints, and no indication that the restraints were removed every two hours to allow for range of motion and skin assessments.</p> <p>The above information regarding Resident R150's restraints were reviewed with the Nursing Home Administrator on October 4, 2024, at 2:07 p.m. The Administrator was unable to explain why Resident R150 was not assessed for restraint use, why the family's consent was not obtained nor why documentation related to the use and release of the restraints was not completed.</p> <p>28 Pa Code 201.18(b)(1) Management</p> <p>28 Pa Code 201.29(c) Resident rights</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>39343</p> <p>Based on review of facility policy, review of clinical records, and staff interviews, it was determined that the facility failed to complete a thorough investigation to rule out neglect related to a fall incident for one of four residents reviewed (Resident R50).</p> <p>Findings Include:</p> <p>Review of facility policy Abuse revealed the policy is intended to provide guidance on investigating and reporting suspected abuse, neglect, and misappropriation of resident property. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.</p> <p>Further review of the facility policy revealed that all reports of abuse, neglect, and injuries of unknown origin shall be promptly and thoroughly investigated by the facility's Administrator. All reports of accidents or incidents involving a resident will be promptly reported and thoroughly investigated by the Administrator, the Director of Nursing, or a designated staff member. Any unusual event or circumstance that is not consistent with the normal routine of the facility, its staff, residents, visitors, etc. This may be a break in procedure or an oversight that could have or has the potential to cause an injury. All accidents or incidents involving a resident must be thoroughly documented in the resident's medical record. At a minimum, such a documentation in the medical record must include: a description of what happened, the action taken, the medical treatment, the preventative measures implemented to prevent such accidents or incidents from recurring, and any other pertinent information. If no cause and effect can be established for an injury, the incident will be defined as origin unknown, and the person conducting the investigation will maintain a record of the incident, the action taken, and the outcome.</p> <p>Review of Resident R50's nursing progress note dated March 7, 2024, indicated; a Licensed Practical Nurse, Employee E33, was notified that Resident R50 fell from his bed. Nurse immediately went to room; resident was found lying on the floor next to his bed. Resident was assessed, positive range of motion to all extremities, resident noted with abrasion to left eyebrow, skin tear to left arm. Resident R50's cholecystectomy tube came out. Physician was made aware, received order to send resident to ER (emergency room) for further evaluation.</p> <p>Review of u-witnessed fall incident description prepared by Licensed nurse, Employee E33, dated March 7, 2024, indicated that R50 was unable to give description.</p> <p>Licensed nurse, Employee E33 was not available for interview.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Event Details dated March 7, 2024, prepared by the then Nursing Home Administrator, Employee E17, and submitted to Department of Health, indicated; investigation in progress, care plan updated, will follow physician orders upon readmission. Update on March 14, 2024: [Resident R50] was still hospitalized , investigation found to be an unwitnessed fall, care plan was followed at the time, . Update on March 22, 2024: [Resident R50]still hospitalized , will update upon readmission or within seven days. Update on March 27, 2024: [Resident R50] returned to facility after unwitnessed fall, care plan updated as appropriate, physician orders being followed, resident was moved closer to nursing station for safety.</p> <p>Resident R50 was not available for observation or interview.</p> <p>On October 4, 2024, at 10:15 a.m., interviewed over telephone the then Administrator, Employee E17. E17 stated that she did not recollect any information pertaining to the incident of Resident R50's fall.</p> <p>On October 4, 2024, at 10:29 a.m., interviewed over telephone the then Nurse Aide, Employee E18. E18 stated that she did not recollect any information pertaining to the incident of Resident R50's fall.</p> <p>On October 4, 2024, at 12:22 p.m., interviewed over telephone the then Director of Nursing Employee E19. She stated that prior to the unwitnessed fall of Resident R50, a Nurse Aide repositioned him, he was placed safe. R50 had skin tear, it was due to the fact that his skin was too fragile, and he used to scratch his skin, also he was admitted with his other wounds from hospital.</p> <p>On October 4, 2024, at 12:49 p.m., interviewed the Nurse Aide, Employee E32. Employee E32 stated that on the date of Resident R50's unwitnessed fall she had provided care to R50, repositioned the resident in bed, there was wedges at the sides of the bed, fall mats on the floor; after repositioning R50, she left the room, after a few minutes, when she passed by the door of R50's room she noticed that R50 was on the floor, and Employee E32 added that the resident himself might have tried to get out of the bed.</p> <p>Further review of clinical records of R50 did not indicate completion of a thorough investigation to rule out neglect or abuse. On October 4, 2024, at 1:02 p.m., interview with the Administrator, Employee E1, and the DON, Employee E2, confirmed that there were no additional documents available for review related to the incident.</p> <p>28 Pa Code 211.12 (d)(5) Nursing services.</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p> <p>28 Pa Code 211.12(d)(1) Nursing services</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>39344</p> <p>Based on clinical record reviews and interviews with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers and discharges for two of six residents reviewed (Residents R26, and R7).</p> <p>Findings include:</p> <p>Clinical record review for Resident R26 revealed a nurse's note, dated June 5, 2024, at 12:25 p.m. which indicated that the resident had abnormal labs, and was transferred to a local hospital for a blood transfusion.</p> <p>Continued clinical record review for Resident R26 revealed a nurse's note, dated June 25, 2024, at 1:06 p.m. which indicated that the resident had low oxygen levels. The physician was notified and ordered for the resident to be transferred to a local hospital for evaluation.</p> <p>Clinical record review for Resident R7 revealed a nurse's note, dated May 5, 2024, at 10:05 p.m. which indicated that the resident was found on the floor and had a hematoma (collection of blood due to injury or trauma) on her head. The physician was notified and ordered for the resident to be transferred to a local hospital for evaluation.</p> <p>Continued clinical record review for Resident R7 revealed a nurse's note, dated May 28, 2024, at 6:21 p.m. which indicated that the resident had abnormal labs. The physician was notified and ordered for the resident to be transferred to a local hospital for a blood transfusion.</p> <p>Further record reviews for Residents R26, and R7 revealed that no documentation was available for review at the time of the survey to indicate that the Office of the State Long-Term Care Ombudsman was notified of the facility-initiated emergency transfers and discharges.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(2) Management</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on clinical record reviews and interviews with staff, it was determined that the PASRR (Preadmission Screening and Resident Review) was not appropriately completed according to the resident assessment for two of two residents reviewed related to PASRR assessments (Residents R28 and R7)).</p> <p>Findings include:</p> <p>The PASRR (Preadmission Screening Resident Review) was created in 1987 through language in the Omnibus Budget Reconciliation Act (OBRA) and it has three goals: to identify individuals with mental illness and/or intellectual disability, to ensure they are placed appropriately, whether in the community or in a nursing facility, and to ensure they receive the services they require for their mental illness or intellectual disability.</p> <p>The PASRR Level 1 must be completed on all persons who are considering admission to a Medicaid certified nursing facility. A Level II PASRR evaluation must be completed if the Level 1 PASRR determined that the person is a targeted person with mental illness or an intellectual disability. The Level II PASRR would determine if placement or continued stay in the requested or current nursing facility is appropriate.</p> <p>Review of Resident R28's Annual MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated June 14, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including depression (mood disorder characterized by low mood, a feeling of sadness, and a general loss of interest in things) and psychotic disorder (loss of contact with reality).</p> <p>Review of Resident R28's PASRR Level I assessment, dated June 16, 2022, revealed that no mental health diagnoses were listed on the assessment.</p> <p>Review of Resident R7's Annual MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], and had diagnoses including anxiety disorder (intense, excessive, persistent worry or fear), depression and psychotic disorder.</p> <p>Review of Resident R7's PASRR Level I assessment, dated September 5, 2023, revealed that no mental health diagnoses were listed on the assessment.</p> <p>Interview on October 4, 2024, at 12:18 p.m. Employee E13, Social Services, confirmed that the PASRR assessments for Residents R28 and R7 were not completed accurately in accordance with their comprehensive assessments.</p> <p>28 Pa. Code 201.14(1) Responsibility of licensee</p>		

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NAME OF PROVIDER OR SUPPLIER Aristacare at East Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 Henry Avenue, 7th Floor Philadelphia, PA 19129	
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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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on observations, clinical records reviews and interviews with staff, it was determined that the facility failed to develop a baseline care plan within 48 hours of admission that includes the instructions needed to provide effective and person-centered care, related to respiratory and enteral feeding needs for one of 14 residents reviewed (Resident R150).</p> <p>Findings include:</p> <p>Observation, on October 1, 2024, at 10:46 a.m. revealed Resident R150 lying in bed. The resident had a tracheostomy (a surgically created hole in your trachea that allows for breathing) and ventilator (machines that act as bellows to move air in and out of the lungs) that were assisting the resident to breath. Continued observation revealed that the resident received a nutritional feeding formula via a pump connected to her gastronomy tube (a surgical opening and placement of a tube though a person's abdominal wall into their stomach).</p> <p>Review of Resident R150's care plan revealed that she was admitted to the facility on [DATE], and had diagnoses including respiratory failure (not enough oxygen passes from your lungs to your blood), dependence on ventilator, tracheostomy, gastrostomy and anoxic brain damage (brain damage caused by lack of oxygen to the brain).</p> <p>Review of Resident R150's Respiratory Administration Records for September and October 2024 revealed that the resident had an 8 XLT Shiley (size and type of tracheostomy). Continued review revealed that the resident required the ventilator every day and night, with settings of Assist Control (mode of ventilation) at 16 breaths per minute, with each breath delivering 500 milliliters of air.</p> <p>Review of Resident R150's physician orders for September and October 2024 revealed there were no orders specifying the resident's size or type of gastronomy tube.</p> <p>Review of Resident R150's baseline care plan, dated September 23, 2024, revealed that the resident required tube feedings to improve weight status. Further review revealed that there was no indication or interventions on the care plan related to size, type or management of the gastronomy tube, no indication of the type of nutritional formula required and no interventions related to weight monitoring.</p> <p>Interview on October 4, 2024, at 11:18 a.m. Employee E12, dietician, confirmed that no baseline care plan was completed for Resident R150 related to her gastronomy tube, nutritional formula and weight monitoring.</p> <p>Continued review of Resident R150's baseline care plan revealed that the resident required oxygen therapy, suctioning, tracheostomy care and ventilator. Further review revealed that there were no goals or interventions related to the resident's respiratory needs.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on October 4, 2024, at 1:49 p.m. Employee E6, Respiratory Director, revealed that she was responsible for creating respiratory care plans for residents and was unable to explain why no goals or interventions were developed to manage Resident R150's respiratory needs.</p> <p>28 Pa. Code 211.5(f)(viii) Medical records</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on observations, review of facility policy, clinical record reviews and interviews with staff, it was determined that the facility failed to develop comprehensive care plans related to substance use disorder, pain management, dialysis access, mental health needs and enteral feeding needs for four of 14 residents reviewed (Residents R203, R7, R28 and R26).</p> <p>Findings include:</p> <p>Review of policy titled Care Plans revealed that the disciplinary team in coordination with the resident, his or her family representative, develops and maintains a care plan for each resident that identifies the highest level of functioning the resident may be expected to attain to our team. All care plans have been designed to identify problem areas incorporate risk factors associated with identified problems build on the resident strengths reflect treatment goals and objectives immeasurable outcomes identify the professional standards that are responsible for each element of care aid in preventing or reducing decline in residence functional status and enhance the optimal functioning of the resident by focusing on a rehabilitative program. Care plans are revised as changes in the residence condition may dictate care plans are reviewed at least quarterly.</p> <p>Review of Resident R203's nursing note dated September 25, 2024, signed by the Director of Nursing (DON) revealed Staff reported concerns that the visitor possibly gave the patient illicit drugs. Went into the room to assess the patient with the doctor. Upon entering the room, the visitor was sitting at bedside holding the resident's hand. The resident appeared impaired, slurring his speech, falling asleep while talking, not tracking with the conversation. The DON Employee E2, nursing supervisor and facility doctor had a discussion with the visitor regarding our concerns related to administering illicit drugs to the resident. Visitor informed that she would require supervised visitation until further notice. The facility physician ordered Narcan as needed for the patient.</p> <p>Review of Resident R203's care plan revealed a plan for residents' history of substance abuse disorders, initiated September 25, 2024, with plan to have supervised visits. Resident drug regimen will be monitored. There no goals or intervention included in this plan.</p> <p>Interview with Nursing Home Administrator, Employee E1 and DON, Employee E2, on October 3, 2024, at 8:45 a.m. confirmed an incident of possible substance abuse which is being monitored and inventions are being developed. The resident has not been restricted to supervised visitors at the time of interview.</p> <p>Review of Resident R7's Annual MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated September 4, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including anxiety disorder (intense, excessive, persistent worry or fear), depression (mood disorder characterized by low mood, a feeling of sadness, and a general loss of interest in things), psychotic disorder (loss of contact with reality) and end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R7's active physician orders revealed an order, dated June 2, 2024, to assess the hemodialysis catheter site on the resident's right chest wall twice per day for signs and symptoms of infection or extravasation (leakage of medications from blood vessels). Continued review revealed another physician's order, dated June 2, 2024, to monitor the resident's fistula for positive bruit (sound of blood flow) and thrill (vibration of blood flow) on the resident's right arm twice per day related to end stage renal disease.</p> <p>Review of Resident R7's care plan, dated initiated September 7, 2023, revealed that the resident needed dialysis related to end stage renal disease. Continued review revealed that there was no indication on the care plan of the resident's two dialysis access sites or which one was used for dialysis treatments.</p> <p>Continued review of Resident R7's care plan revealed that the resident uses antidepressant medications and psychotropic medications. Further review revealed that there were no specific care plans developed related to resident's anxiety, depression and psychotic disorder or any non-pharmacologic interventions to manage the resident's mental health needs.</p> <p>Review of Resident R28's Annual MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], and had diagnoses including depression, psychotic disorder and gastrostomy tube (a surgical opening and placement of a tube through a person's abdominal wall into their stomach).</p> <p>Review of Resident R28's care plan, dated initiated June 27, 2022, revealed that the resident required tube feedings to meet his nutritional needs. Continued review revealed that there was no indication or interventions on the care plan related to size, type or management of the resident's gastrostomy tube.</p> <p>Continued review of Resident R28's care plan revealed that the resident uses anti-anxiety medications. Further review revealed that there were no specific care plans developed related to resident's depression and psychotic disorder or any non-pharmacologic interventions to manage the resident's mental health needs.</p> <p>Observation, on October 1, 2024, at 10:27 a.m. revealed that Resident R26 revealed received a nutritional feeding formula via a pump connected to his gastrostomy tube (a surgical opening and placement of a tube through a person's abdominal wall into their stomach).</p> <p>Review of Resident R26's Quarterly MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], and had diagnoses including dysphagia (difficulty swallowing).</p> <p>Review of Resident R26's care plan, dated initiated September 30, 2024, revealed that the resident required tube feedings to meet his nutritional needs. Continued review revealed that there was no indication or interventions on the care plan related to size, type or management of the resident's gastrostomy tube. Further review of Resident R26's care plan revealed that there was no care plan in place regarding the resident's nutritional status from his admission to the facility until September 30, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The above information regarding Residents R7, R28 and R26 were reviewed with the Nursing Home Administrator on October 4, 2024, at 11:26 a.m. The Administrator was unable to explain why care plans had not been developed for Residents R7, R28 and R26 regarding their dialysis access, gastronomy tubes and mental health needs.</p> <p>28 Pa. Code 211.5(f)(viii) Medical records</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>39343</p> <p>Based on observations, clinical record review, review of facility documents and staff interviews, it was determined that the facility failed to revise the care plan for nutrition, mobility, and skin integrity, for three of 14 residents reviewed (Residents R1, R12 and R39).</p> <p>Findings include:</p> <p>Review of Resident R1's clinical record revealed that the resident was admitted in the facility on July 12, 2024. Resident R1's diagnoses included: Anemia (Anemia is a blood disorder that happens when an individual don't have enough red blood cells or the red blood cells don't work as they should). Cerebral Palsy (a group of neurological disorders that affect a person's ability to move, balance, and maintain posture. It's caused by damage to or abnormal development of the brain during a person's infancy or early childhood), Anxiety Disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and Respiratory Failure (Respiratory failure is a serious condition that occurs when the lungs can't get enough oxygen into the blood or remove enough carbon dioxide from the body).</p> <p>Review of Dietary and Nutrition Services Progress Note, dated October 3, 2024, for Resident R1, indicated Monthly High Risk Nutritional Assessment for Tube Feeding, along with the goal for weight to stabilize.</p> <p>Review of the weight assessment record of Resident R1 indicated fluctuation.</p> <p>Review of the care plan for Resident R1, indicated that the resident's Tube Feeding- care plan, initiated on May 16, 2024, with the target date of June 11, 2024, was not updated, or revised, to reflect the interventional status, based on the resident's nutritional requirements.</p> <p>On October 3, 2024, at 1:17 p.m., the DON, confirmed the findings regarding the lack of revision and updating of the care plan for Resident R1, related with the nutritional care.</p> <p>Review of Resident R12's clinical record revealed that the resident was admitted in the facility on March 8, 2024. Residnet R12's diagnoses included: Myasthenia Gravis (Myasthenia gravis (MG) is a chronic autoimmune disease that causes muscle weakness. It occurs when the body's immune system produces antibodies that attack the neuromuscular junction, blocking the chemical that signals muscles to contract. This results in fluctuating muscle weakness that worsens with activity and improves with rest), and left-hand contracture.</p> <p>Review of the care plan for Residnet R12, indicated that the care plan for Residnet R12's Activities of Daily Life Self Care Performance Deficit related to Limited Mobility, and Limited Range of Motion, initiated on March 9, 2024, with the target date of September 4, 2024, was not updated, or revised, to reflect the interventional status, based on the resident's mobility care requirements.</p> <p>On October 3, 2024, at 1:17 p.m., the DON, confirmed the findings regarding the lack of revision and updating of the care plan for R12, related with the mobility care.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R39's clinical record revealed that the Resident was admitted in the facility on October 25, 2023. R39's diagnoses included: Hydrocephalus (Hydrocephalus, is a neurological condition that occurs when too much cerebrospinal fluid (CSF) builds up in the brain's ventricles), Anemia, and Severe Protein-Calorie Malnutrition.</p> <p>Review of Physician order for Resident R39, dated August 23, 2024, indicated: Tube Feeding(T/F), two times a day, Vital 1.5 @ 70 mL/hr x 22hr (1540mL TV) Down at 4am up at 6am.</p> <p>On October 3, 2024, at 9:49 AM, observed that Residnet R39 was administered with the tube feeding as ordered.</p> <p>Review of the care plan for Residnet R39, indicated that the care plan for R39's Tube Feeding, initiated on October 26, 2023, with revision date of July 9, 2024, stated as: TF order: Osmolite 1.5 @ 65 mL/hr x 22 hrs for TV 1430 mL/d. FWF 220 mL q 6 hrs. The care plan was not updated, or revised, to reflect the interventional status, based on the resident's Tube Feeding Orders.</p> <p>On October 3, 2024, at 9:54 AM, Employee E5, a Licensed Nurse, confirmed the findings regarding the lack of revision and updating of the care plan for R39, related with the Tube Feeding Orders.</p> <p>28 Pa Code 211.5(f) Clinical records</p> <p>28 Pa Code 211.11(d) Resident Care Plan</p> <p>28 Pa Code 211.12(c)(d)(3) Nursing services</p> <p>28 Pa Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on review of facility policies, review of facility documentation, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that the resident and their representatives were involved in an effective discharge planning process for one of three residents reviewed. (Resident R49)</p> <p>Findings include:</p> <p>Review of facility policy titled Discharging a Resident Against Medical Advice revealed that should a resident request immediate discharge the residents attending physician must be promptly notified as the residents representative have the right to make decisions for their own care should they resident request discharge from the facility.</p> <p>Review of the facility document [NAME] of Rights under the heading Discharges and Transfers given to all residents at time of admission revealed to discharge yourself from the nursing home the resident must present a signed release signed the resident or the resident's guardian.</p> <p>Review of Resident R49's Minimum Data Set (MDS- a federal mandated process of assessments for all long term care facility resident) admission assessment dated [DATE] revealed that Resident R49 was admitted into the facility July 30, 2024 with diagnosis' including heart failure, respiratory failure, pulmonary disease, and dependence on continuous positive airway pressure(CPAP- a machine that uses air pressure to keep breathing airways open).</p> <p>The resident is assessed of having a cognitive BIMS(brief interview for mental status) score of 15, indicating the resident's cognitive status is intact.</p> <p>Review of Resident R49's care plan revealed a plan for discharge including to coordinate arrangements with required resources to support safe, and to establish a pre-discharge plan with the resident/family/caregivers and evaluate progress and revise plan as needed, Initiated on July 31, 2024 .</p> <p>Review of Resident 49's clinical record revealed no physician orders or physician notification of the resident's discharge. There was no discharge summary or indication that the resident was referred to home care. Continued review of Resident R49's clinical record revealed a social service note dated September 16, 2024: Resident discharged AMA (against medical advise) to home. He stated he didn't need any equipment and that he had everything at home. Oxygen, wheelchair, walker. He ordered his own stretcher to pick him up from facility. SSD made referral to Immediate home care to help discharge be as safe as possible.</p> <p>Review of facility document Discharge Against Medical Advice stated that Resident R49 released the facility and its employees and physician of all responsibility of Resident R49's care. Continued review of this form revealed that Resident R49 did not sign the release. There are two witness signatures Social Service Director, Employees E13 and Director of Nursing, Employee E2 and dated September 16, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Social Service Director Employee E13 on October 3, 2024 at 9:15 a.m. revealed, this employee has had many conversations with Residents R49, regarding leaving against medical advice. Employee E13 stated that there were referrals made for continued home care, the residents stated that he was educated on his care and medications, and a number for transportation was provided to Resident R49 . Employee E13 confirmed that there was no documentation of any attempts made. Employee E49 stated that this employee was not present at the time of discharge.</p> <p>Interview with Director of Nursing, Employee E2, October 3, 2024 at 2:45 p.m. revealed that it is unknown why the resident did not sign the form.</p> <p>28 Pa. Code 201.4(a) Responsibility of licensee</p> <p>28 pa code 201. 25 (a)Discharge policy</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 39344</p> <p>Based on clinical record reviews and interviews with staff, it was determined that the facility failed to follow physician orders related to blood pressure medications for one of 14 residents reviewed (Resident R7).</p> <p>Findings include:</p> <p>Review of Resident R7's Annual MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated September 4, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including heart failure (a chronic condition in which the heart doesn't pump blood as well as it should) and end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life).</p> <p>Review of physician orders for Resident R7 revealed on order, dated June 6, 2024, for midodrine 5 milligrams, give one tablet by mouth two times per day (9:00 and 9:00 p.m.) for hypotension (low blood pressure), hold for systolic blood pressure (SBP) greater than 110.</p> <p>Review of Medication Administration Records for Resident R7 revealed that following:</p> <p>On July 1, 2024, at 9:00 p.m. the resident's SBP was 157 and midodrine was administered;</p> <p>On July 2, 2024, at 9:00 a.m. the resident's SBP was 125 and midodrine was administered;</p> <p>On July 3, 2024, at 9:00 a.m. the resident's SBP was 142 and midodrine was administered;</p> <p>On July 4, 2024, at 9:00 p.m. the resident's SBP was 145 and midodrine was administered;</p> <p>On July 5, 2024, at 9:00 p.m. the resident's SBP was 129 and midodrine was administered;</p> <p>On July 8, 2024, at 9:00 a.m. the resident's SBP was 112 and midodrine was administered;</p> <p>On July 9, 2024, at 9:00 p.m. the resident's SBP was 134 and midodrine was administered;</p> <p>On July 11, 2024, at 9:00 p.m. the resident's SBP was 119 and midodrine was administered;</p> <p>On July 12, 2024, at 9:00 a.m. the resident's SBP was 121 and midodrine was administered;</p> <p>On July 14, 2024, at 9:00 a.m. the resident's SBP was 165 and midodrine was administered;</p> <p>On July 15, 2024, at 9:00 a.m. the resident's SBP was 165 and midodrine was administered;</p> <p>On July 19, 2024, at 9:00 p.m. the resident's SBP was 113 and midodrine was administered;</p> <p>On July 21, 2024, at 9:00 p.m. the resident's SBP was 140 and midodrine was administered;</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 - Some</p>	<p>On July 22, 2024, at 9:00 p.m. the resident's SBP was 150 and midodrine was administered;</p> <p>On July 25, 2024, at 9:00 a.m. the resident's SBP was 129 and midodrine was administered;</p> <p>On July 28, 2024, at 9:00 a.m. the resident's SBP was 150 and midodrine was administered;</p> <p>On July 28, 2024, at 9:00 p.m. the resident's SBP was 148 and midodrine was administered;</p> <p>On July 29, 2024, at 9:00 p.m. the resident's SBP was 126 and midodrine was administered;</p> <p>On July 30, 2024, at 9:00 a.m. the resident's SBP was 116 and midodrine was administered;</p> <p>On July 30, 2024, at 9:00 p.m. the resident's SBP was 156 and midodrine was administered;</p> <p>On July 31, 2024, at 9:00 p.m. the resident's SBP was 133 and midodrine was administered;</p> <p>On August 3, 2024, at 9:00 a.m. the resident's SBP was 132 and midodrine was administered;</p> <p>On August 4, 2024, at 9:00 a.m. the resident's SBP was 142 and midodrine was administered;</p> <p>On August 4, 2024, at 9:00 p.m. the resident's SBP was 142 and midodrine was administered;</p> <p>On August 6, 2024, at 9:00 p.m. the resident's SBP was 127 and midodrine was administered;</p> <p>On August 10, 2024, at 9:00 p.m. the resident's SBP was 128 and midodrine was administered;</p> <p>On August 11, 2024, at 9:00 p.m. the resident's SBP was 138 and midodrine was administered;</p> <p>On August 12, 2024, at 9:00 p.m. the resident's SBP was 111 and midodrine was administered;</p> <p>On August 13, 2024, at 9:00 p.m. the resident's SBP was 116 and midodrine was administered;</p> <p>On August 15, 2024, at 9:00 a.m. the resident's SBP was 112 and midodrine was administered;</p> <p>On August 16, 2024, at 9:00 a.m. the resident's SBP was 124 and midodrine was administered;</p> <p>On August 17, 2024, at 9:00 p.m. the resident's SBP was 112 and midodrine was administered;</p> <p>On August 22, 2024, at 9:00 p.m. the resident's SBP was 118 and midodrine was administered;</p> <p>On August 23, 2024, at 9:00 a.m. the resident's SBP was 114 and midodrine was administered;</p> <p>On August 24, 2024, at 9:00 a.m. the resident's SBP was 132 and midodrine was administered;</p> <p>On August 24, 2024, at 9:00 p.m. the resident's SBP was 149 and midodrine was administered;</p> <p>On August 25, 2024, at 9:00 a.m. the resident's SBP was 119 and midodrine was administered;</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 - Some</p>	<p>On August 29, 2024, at 9:00 a.m. the resident's SBP was 124 and midodrine was administered;</p> <p>On August 30, 2024, at 9:00 p.m. the resident's SBP was 155 and midodrine was administered;</p> <p>On August 31, 2024, at 9:00 a.m. the resident's SBP was 120 and midodrine was administered;</p> <p>On September 1, 2024, at 9:00 p.m. the resident's SBP was 124 and midodrine was administered;</p> <p>On September 9, 2024, at 9:00 p.m. the resident's SBP was 116 and midodrine was administered;</p> <p>On September 12, 2024, at 9:00 a.m. the resident's SBP was 124 and midodrine was administered;</p> <p>On September 14, 2024, at 9:00 p.m. the resident's SBP was 154 and midodrine was administered;</p> <p>On September 15, 2024, at 9:00 a.m. the resident's SBP was 124 and midodrine was administered;</p> <p>On September 16, 2024, at 9:00 a.m. the resident's SBP was 130 and midodrine was administered;</p> <p>On September 18, 2024, at 9:00 p.m. the resident's SBP was 142 and midodrine was administered;</p> <p>On September 25, 2024, at 9:00 a.m. the resident's SBP was 121 and midodrine was administered.</p> <p>Review of Consultant Pharmacist Reports for Resident R7 revealed a Nursing Summary report, dated July 29, 2024, which indicated, Medication error(s) noted. Midodrine is not always held as required by the physician's hold order. Please review and follow the physician's order. The report was initialed and signed as completed on August 15, 2024.</p> <p>Continued review of Consultant Pharmacist Reports for Resident R7 revealed a Nursing Summary report, dated August 30, 2024, which indicated, Medication error(s) noted. Midodrine is not always held as required by the physician's hold order. Please review and follow the physician's order. The report was initialed but not dated.</p> <p>Further review of Consultant Pharmacist Reports for Resident R7 revealed a Nursing Summary report, dated September 20, 2024, which indicated, Medication error(s) noted. Midodrine is not always held as required by the physician's hold order. Please review and follow the physician's order. The report was neither initialed nor dated.</p> <p>The above medication errors were reviewed with the Nursing Home Administrator on October 4, 2024, at 6:54 p.m. The Administrator was unable to explain why nursing staff did not administer Resident R7's midodrine per the physician's orders.</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on observations, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to provide adequate monitoring to prevent complications related to enteral feeding for two of four residents reviewed for tube feedings (Residents R150 and R26).</p> <p>Findings include:</p> <p>Observation, on October 1, 2024, at 10:46 a.m. revealed Resident R150 lying in bed and receiving a nutritional feeding formula via a pump connected to her gastronomy tube (a surgical opening and placement of a tube through a person's abdominal wall into their stomach).</p> <p>Review of Resident R150's care plan revealed that she was admitted to the facility on [DATE], and had diagnoses including gastrostomy and anoxic brain damage (brain damage caused by lack of oxygen to the brain).</p> <p>Review of physicians' orders for Resident R150 revealed an order, dated September 21, 2024, to obtain weight at admission and then weekly weights time four weeks for a total of five weeks.</p> <p>Review of weights for Resident R150 revealed that on September 21, 2024, the resident weighed 267.8 pounds; on October 2, 2024, the resident weighed 291.6 pounds which is an 8.89% gain. Further review revealed that there were no other weights for Resident R150 available for review.</p> <p>Interview on October 4, 2024, at 11:18 a.m. Employee E12, dietician, confirmed that Resident R150 had a significant weight gain. Employee E12, dietician stated that she was in the process of obtaining another weight for the resident. Employee E12, dietitian, was unable to explain why weights were not obtained weekly as ordered by the physician.</p> <p>Observation, on October 1, 2024, at 10:27 a.m. revealed that Resident R26 revealed received a nutritional feeding formula via a pump connected to his gastronomy tube (a surgical opening and placement of a tube through a person's abdominal wall into their stomach).</p> <p>Interview on October 2, 2024, at 10:30 a.m. Resident R26's family member stated that several days ago the resident's gastronomy tube came out and that a nurse re-inserted that same tube back into the resident. Resident R26's family member stated that he was concerned about the tube's placement and wanted the resident to be evaluated by a physician.</p> <p>Review of Resident R26's Quarterly MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], and had diagnoses including dysphagia (difficulty swallowing).</p> <p>Review of progress notes for Resident R26 revealed a nurses note, dated September 21, 2024, at 2:11 a.m. which stated, 2/9 S/P [status post] G-tube [gastronomy] change. No issues noted. G-tube patent, intact infusing enteral feed. No infection noted peri stoma. Safety and aspiration precaution maintained.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of progress notes for Resident R26 revealed a physicians note, dated September 24, 2024, at 9:59 a. m. revealed, Peg tube [gastronomy] malfunctioning script given for replacement. Continued review revealed that the physician continued to recommend gastronomy tube replacement in their notes dated September 25, 26, 27, 30, and October 1 and 3, 2024.</p> <p>Further review of progress notes for Resident R26 revealed that there no notes related to the gastronomy tube coming out or when it was reinserted by staff.</p> <p>Review of physician orders for Resident R26 revealed that there were no orders instructing staff to reinsert or change the resident's gastronomy tube, nor any orders specifying the type and size of tube that the resident required.</p> <p>Interview on October 4, 2024, at 11:26 a.m. with the Nursing Home Administrator revealed that she was unable to explain why no note had been written related to Resident's R26's gastronomy tube change and stated that the physician had met with the family and assessed the resident's gastronomy tube.</p> <p>28 Pa Code 211.5(f)(i)(iii) Medical records</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343</p> <p>Based on observations, review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to provide care and assessments consistent with professional standards of practice related to intravenous therapy for three of three residents reviewed (Residents R43, R44, and R150).</p> <p>Findings include:</p> <p>Review of facility policy, Central Vascular Access Device (CVAD) Dressing Change dated January 17, 2019, revealed that CVADs include peripherally inserted central catheters (PICC) and subclavian catheters (catheter inserted into the vein near the collar bone). Continued review revealed that dressing changes are performed 24 hours post-insertion or upon admission and at least weekly. Continued review revealed that assessment of the CVAD is performed upon admission, during dressing changes, before and after administration of intermittent infusions and at least once every shift when not in use. Further review revealed that assessment of the arm with the CVAD includes, but is not limited to, erythema (redness), drainage, swelling and change in skin temperature at site.</p> <p>Review of facility policy, Midline Dressing Changes dated January 17, 2019, revealed, Change midline catheter dressing 24 hours after catheter insertion, every 5 to 7 days, or if it is wet, dry, not intact or compromised in any way.</p> <p>Review of facility policy, Flushing Central Venous and Midline Catheters dated January 17, 2019, revealed, Midline and central line access devices (CVADs) will be flushed to maintain patency, to prevent mixing of incompatible medications and solutions, and to ensure entire dosage of solution or medication is administered into the venous system.</p> <p>A review of the clinical record for Resident R43 revealed that the resident was admitted to the facility on [DATE], with diagnoses including Anoxic Brain Damage (Anoxic brain injuries are caused by a complete lack of oxygen to the brain, which results in the death of brain cells after approximately four minutes of oxygen deprivation).</p> <p>Review of physician order for Resident R43, dated September 27, 2024, indicated: Meropenem Intravenous Solution Reconstituted 1 GM (Meropenem), Use 1 gram intravenously three times a day for Proteus Mirabilis Esbl + Pseudomonas Aeruginosa (disease causing organisms) for 14 Days.</p> <p>Review of physician order for Resident R43, dated October 1, 2024, indicated: Change PICC line dressing weekly and as needed, one time a day every 7 day(s). PICC line (peripherally inserted central catheter) is a thin, flexible tube that's inserted into a vein in the arm and threaded into a large vein near the heart; PICCs are used to administer intravenous (IV) fluids, blood transfusions, chemotherapy, and other drugs etc.).</p> <p>Review of the Medication Administration Record (MAR), on October 1, 2024, for Resident R43 revealed, no documentation in relation to the care of PICC line.</p> <p>(continued on next page)</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on October 1, 2024, at 1:09 p.m., revealed that the PICC line had a dressing, but without any date of the dressing marked on it. The finding was confirmed with Employee E5, a Licensed Nurse, at the time of the observation.</p> <p>Interview with Employee E5, on October 1, 2024, at 1:19 p.m., confirmed the findings.</p> <p>A review of the clinical record for Resident R44 revealed that the resident was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure with Hypoxia (occurs when the body doesn't receive enough oxygen due to damaged or narrowed airways).</p> <p>Review of physician order for Resident R44, dated September 25, 2024, indicated: Change IV dressing, needleless connector (caps), measure external catheter length and circumference of arm 3 cm above IV insertion site Q weekly from the day of pt arrival to facility or from time of insertion or as needed, every day shift every Tuesday change IV dressing, needleless connector (caps), measure external catheter length and circumference of arm 3 cm above IV insertion site Q (every) weekly from the day of pt arrival to facility or from time of insertion or as needed, and every 12 hours as needed for soiling/removal.</p> <p>Review of the Medication Administration Record (MAR), on October 1, 2024, for Resident R44 revealed, no documentation in relation to the care of PICC line.</p> <p>Observation on October 1, 2024, at 1:02 PM, revealed that the intravenous line had a dressing, but without any date of the dressing marked on it. The finding was confirmed with Employee E5, a Licensed Nurse, at the time of the observation.</p> <p>Interview with Employee E5, a Licensed Practical Nurse, On October 1, 2024, at 1:19 PM, confirmed the findings.</p> <p>Observation, on October 1, 2024, at 11:04 a.m. revealed that Resident R150 had a double lumen PICC line in her left upper arm. The dressing was dated September 17, 2024, and was peeling away from the resident's skin. Interview, at the time of the observation, Employee E7, licensed nurse, stated that the dressing needs to be changed. Continued interview revealed that Employee E7, licensed nurse, was not aware of any medications or fluids that Resident R150 received through her PICC line. Further interview revealed that Employee E7, licensed nurse, was unsure how often PICC line dressings should be changed and stated that she usually gets the registered nurse on duty to do any intravenous care.</p> <p>Review of progress notes for Resident R150 revealed a nurses note, dated September 21, 2024, at 6:12 p. m. which indicated that the resident was admitted to the facility and that she had a left upper arm double lumen intravenous line.</p> <p>Review of physician orders for Resident R150 revealed that there were no orders for the resident regarding any infusions or any care and maintenance of her PICC line.</p> <p>Continued review of physician orders for Resident R150 revealed an order, dated October 1, 2024, to remove the resident's PICC line.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of progress notes for Resident R150 revealed that there were note notes related to the removal of the resident's PICC line.</p> <p>Interview on October 4, 2024, at 2:00 p.m. the Nursing Home Administrator was unable to explain why Resident R150's PICC line was not assessed, maintained or removed, from the time of the resident's admission to the facility through October 1, 2024.</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12(d)(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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on review of facility documentation, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that residents received dialysis services consistent with professional standards of practice related to fluid restrictions and dialysis access for one of one residents reviewed who received dialysis services (Resident R7).</p> <p>Findings include:</p> <p>Review of the facility's affiliation agreement with a contracted dialysis agency, dated September 1, 2018, revealed that the facility will notify the dialysis facility when a dialysis resident refuses scheduled medical management or demonstrates non-compliance with medical management related to renal replacement therapy, i.e., diet, fluid restriction, and medications.</p> <p>Review of Resident R7's Annual MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated September 4, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including heart failure (a chronic condition in which the heart doesn't pump blood as well as it should) and end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life).</p> <p>Review of Resident R7's care plan, dated initiated September 7, 2023, revealed that the resident needs dialysis (the process of removing waste products and excess fluid from the body; dialysis is necessary when the kidneys are not able to adequately filter the blood) related to end stage renal disease. Interventions included for the resident to receive dialysis Monday through Friday, to monitor labs, to monitor vital signs and to monitor and signs or symptoms of infection to the access site.</p> <p>Continued review of Resident R7's care plan revealed that the resident was at nutritional risk due to end stage renal disease with interventions including 1500 mL (milliliter) fluid restriction.</p> <p>Review of Resident R7's active physician orders revealed an order, dated June 2, 2024, to assess the hemodialysis catheter site on the resident's right chest wall twice per day for signs and symptoms of infection or extravasation (leakage of medications from blood vessels). Continued review revealed another physician's order, dated June 2, 2024, to monitor the resident's fistula for positive bruit (sound of blood flow) and thrill (vibration of blood flow) on the resident's right arm twice per day related to end stage renal disease.</p> <p>Continued review of Resident R7's active physician orders revealed an order, dated June 5, 2024, for renal diet with 1500 mL fluid restriction (720 mL dietary, 780 mL nursing).</p> <p>Review of Resident R7's medication and treatment records for September and October 2024, revealed that there was no documentation of any fluid intake monitoring or compliance with fluid restrictions for the resident.</p> <p>Review of progress notes for Resident R7 revealed a Cardiology physician's note, dated September 2, 2024, at 11:58 p.m. with recommendations to continue fluid restriction.</p> <p>(continued on next page)</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>Review of Resident R7's dialysis communication reports, dated September 11, 12, 13, 16, 17, 18, 19, 20, 23, 25, 26, 27, 30, 2024 and October 1, 2024, revealed that there was no indication if the resident was compliant with diet or fluid restrictions; and no indication of the resident's location, type or assessment of the dialysis access site.</p> <p>Interview on October 4, 2024, at 11:18 a.m. Employee E12, dietician, confirmed that there was no documentation or monitoring of Resident R7's compliance with her prescribed fluid restrictions.</p> <p>Interview on October 4, 2024, at 11:26 a.m. the Nursing Home Administrator was unable to explain why there was no communication between the facility and the dialysis agency regarding Resident R7's fluid restriction compliance or assessment of her dialysis access site.</p> <p>28 Pa Code 211.12(d)(3) Nursing services</p> <p>28 Pa Code 211.12(d)(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 - Some</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>39344</p> <p>Based on a review of personnel files and interviews with staff, it was determined that the facility failed ensure that nursing staff had specific competencies and skills sets necessary to care for residents' needs for seven of 13 personnel files reviewed (Employees E22, E10, E23, E24, E4, E25 and E26).</p> <p>Findings include:</p> <p>Review of the facility's Resident Matrix, dated October 4, 2024, revealed that 40 residents required tracheostomy (a surgically created hole in your trachea that allows for breathing) care, 22 residents required ventilator (machines that act as bellows to move air in and out of the lungs) care, three residents required intravenous therapy and two residents had physical restraints.</p> <p>Review of Employee E22's personnel file revealed that the employee was hired by the facility on August 14, 2024, as a registered nurse. Continued review revealed that there was no indication that the employee was evaluated or received skill competency training related to restraints, tracheostomies, ventilators, airway suctioning, oxygen administration, emergency airway management or intravenous therapy including dressing changes, line management and assessment.</p> <p>Review of Employee E10's personnel file revealed that the employee was hired by the facility on August 1, 2024, as a licensed practical nurse. Continued review revealed that there was no indication that the employee was evaluated or received skill competency training related to restraints, tracheostomies, ventilators, airway suctioning, oxygen administration, emergency airway management or intravenous therapy including dressing changes, line management and assessment.</p> <p>Review of Employee E23's personnel file revealed that the employee was hired by the facility on August 15, 2024, as a nurse aide. Continued review revealed that there was no indication that the employee was evaluated or received skill competency training related to restraints or providing residents with feeding assistance.</p> <p>Review of Employee E24's personnel file revealed that the employee was hired by the facility on August 12, 2024, as a nurse aide. Continued review revealed that there was no indication that the employee was evaluated or received skill competency training related to restraints or providing residents with feeding assistance.</p> <p>Trainings and competency evaluations for agency staff, Employee E4, licensed practical nurse, Employee E25, licensed practical nurse, and Employee E26, nurse aide, were requested from the Nursing Home Administrator on October 3, 2024, at 12:19 p.m.</p> <p>Interview on October 4, 2024, at 2:07 p.m. the Nursing Home Administrator revealed that skills competencies evaluations and trainings related to restraints, tracheostomies, ventilators, oxygen, airway management, intravenous therapy and feeding assistance were not available for review at the time of the survey for Employees E22, E10, E23 and E24.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Follow-up interview on October 4, 2024, at 6:54 p.m. the Nursing Home Administrator revealed that trainings or skills competencies evaluations were not available for review at the time of the survey for agency Employees E4, E25 and E26.</p> <p>28 Pa Code 201.19(7) Personnel policies and procedures</p> <p>28 Pa Code 211.12(d)(2) Nursing services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>39344</p> <p>Based on observations and interviews with facility staff, it was determined that the facility failed to accurately post information regarding daily nurse staffing data as required.</p> <p>Findings include:</p> <p>Observation on October 1, 2024, at 10:20 a.m. revealed that the daily staffing data was posted at the front desk of the lobby. The posted data did not include the facility's name or actual hours worked by nursing staff.</p> <p>Observation on October 2, 2024, at 10:28 a.m. revealed that the daily staffing data was posted at the front desk of the lobby. The posted data did not include the facility's name or actual hours worked by nursing staff.</p> <p>Observation on October 3, 2024, at 12:07 p.m. revealed that the daily staffing data was posted at the front desk of the lobby. The posted data did not include the facility's name or actual hours worked by nursing staff.</p> <p>Observation on October 4, 2024, at 8:37 a.m. revealed that the daily staffing data was posted at the front desk of the lobby. The posted data did not include the facility's name or actual hours worked by nursing staff.</p> <p>Interview on October 4, 2024, at 2:07 p.m. the Nursing Home Administrator confirmed that the posted staffing data did not have all the required information.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343</p> <p>Based on review of facility documentation, clinical record reviews and interviews with staff, it was determined that the facility failed to provide routine medications to meet residents' needs for two of 14 residents reviewed (Residents R45 and R22).</p> <p>Findings include:</p> <p>Review of Resident R45's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated September 12, 2024, revealed that the resident was admitted to the facility on [DATE], was in a persistent vegetative state and had diagnoses including hypertension (high blood pressure), seizures (abnormal electrical activity in the brain), anoxic brain damage (brain damage caused by lack of oxygen to the brain) and dependence on ventilator (machines that act as bellows to move air in and out of the lungs).</p> <p>Review of Medication Administration Records (MARs) for Resident R45 revealed a physician's order, dated September 19, 2024, for fluconazole (medication used to treat fungal infections) administer one tablet once per day for seven days. Continued review revealed that on September 19 and 20, 2024, the doses were not administered due to Other/See Progress Notes. Review of eMAR (electronic MAR) notes revealed that the medication was not administered due to on order.</p> <p>Continued review of MARs for Resident R45 revealed a physician's order, dated September 17, 2024, for baclofen (medication used to treat muscle spasms) administer one tablet twice per day at 6:00 a.m. and 5:00 p.m. Continued review revealed that the MAR was blank on September 20, 2024, at 5:00 p.m. and on September 29, 2024, at 5:00 p.m. There were no notes to indicate whether the medication was administered.</p> <p>Continued review of MARs for Resident R45 revealed a physician's order, dated September 6, 2024, for lacosamide (medication used to treat seizures) administer one tablet every twelve hours at 9:00 a.m. and 9:00 p.m. Continued review revealed that on September 6,7 and 11, 2024, the 9:00 p.m. doses and the September 11, 2024, 9:00 a.m. dose were not administered due to Other/See Progress Notes. Review of eMAR notes revealed that the medication was not administered due to awaiting arrival.</p> <p>Continued review of MARs for Resident R45 revealed a physician's order, dated September 7, 2024, for miconazole powder (medication used to treat fungal infections) apply to both axilla topically every twelve hours at 9:00 a.m. and 9:00 p.m. Continued review revealed that on September 7, 8, 9 and 12, 2024, the 9:00 p.m. doses were not administered due to Other/See Progress Notes. Review of eMAR notes revealed that the medication was not administered due to on order.</p> <p>Continued review of MARs for Resident R45 revealed a physician's order, dated September 7, 2024, for gabapentin (medication used to treat nerve pain) administer one tablet three times per day at 6:00 a.m., 2:00 p.m. and 10:00 p.m. Continued review revealed that the MAR was blank on September 7, 2024, at 2:00 p.m., September 8, 2024, at 6:00 a.m. and on September 20, 2024, at 2:00 p.m. There were no notes to indicate whether the medication was administered.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of MARs for Resident R45 revealed a physician's order, dated September 6, 2024, for propranolol (medication used to treat high blood pressure) administer one tablet every eight hours at 6:00 a. m., 2:00 p.m. and 10:00 p.m. Continued review revealed that the MAR was blank on September 7, 2024, at 2:00 p.m., September 8, 2024, at 6:00 a.m. and on September 20, 2024, at 2:00 p.m. There were no notes to indicate whether the medication was administered.</p> <p>Continued review of MARs for Resident R45 revealed a physician's order, dated September 7, 2024, for guaifenesin (medication used to treat cough) administer 600 milligrams every six hours at 12:00 a.m., 6:00 a. m., 12:00 p.m. and 6:00 p.m. Continued review revealed that the MAR was blank on September 7, 2024, at 12:00 p.m. and 6:00 p.m., September 8, 2024, at 6:00 a.m., September 18, 2024, at 6:00 p.m., September 20, 2024, at 6:00 p.m. and on September 29, 2024 at 6:00 p.m. There were no notes to indicate whether the medication was administered. Continued review revealed that the September 8, 2024, at 12:00 p.m., September 16, 2024, at 6:00 p.m., September 17, 2024, at 6:00 a.m. and the September 18, 2024, at 12:00 a. m. and 6:00 a.m. doses were not administered due to Other/See Progress Notes. Review of eMAR notes revealed that the medication was not administered due to medication not available.</p> <p>Review of the facility's emergency medication supply inventory, dated September 18, 2024, revealed that fluconazole, baclofen and gabapentin were available for use at the facility.</p> <p>Interview on October 4, 2024, at 6:54 p.m. the Nursing Home Administrator was unable to explain why Resident R45's medications were not administered.</p> <p>Interview with Resident R22 on October 1, 2024, at 11:05 a.m. revealed that she had some concerns regarding her medication. Resident R22 stated that she was diagnosed with a vaginal yeast infection and prescribed a medication but has not received it yet. Resident R22 continued to ask staff for the medication but was told that the facility does not have it.</p> <p>Review of resident R22's clinical record revealed physician orders that resident R22 was ordered fluconazole 150 mg externally on September 22, 2024 for one time a day for five days.</p> <p>Review of residents MAR (medication administration record) revealed that resident R22 did not receive the medication fluconazole on September 23, and 25, 2024 .</p> <p>Review of facility document from pharmacy revealed an email from the pharmacy that they called and requested clarification and was delayed delivery. The Resident missed 2 days of medication.</p> <p>28 Pa Code 201.18(b)(1) Management</p> <p>28 Pa Code 211.12(d)(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 - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on clinical record reviews and interviews with staff, it was determined that the facility to ensure that the consultant pharmacist medication reviews were completed and that recommendations were reviewed by the physician in a timely manner for three of eight residents reviewed for medication regime reviews (Residents R38, R26, R7).</p> <p>Findings include:</p> <p>Review of Resident R38's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated August 16, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), respiratory failure (not enough oxygen passes from your lungs to your blood), anxiety disorder (intense, excessive, persistent worry or fear), tracheostomy (a surgically created hole in your trachea that allows for breathing) and dependence on ventilator (machines that act as bellows to move air in and out of the lungs).</p> <p>Continued review of Resident R38's clinical record revealed that no consultant pharmacist medication reviews were available for review at the time of the survey.</p> <p>Review of Resident R26's Quarterly MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], and had diagnoses including dysphagia (difficulty swallowing), end stage renal disease, dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), encephalopathy (damage or disease that affects the brain) and respiratory failure.</p> <p>Review of Resident R26's consultant pharmacist medication report, dated May 27, 2024, revealed that seven recommendations were made by the pharmacist. Continued review revealed that the report was not signed and dated and did not indicate if the recommendations were implemented or not.</p> <p>Review of Resident R26's consultant pharmacist medication report, dated June 14, 2024, revealed that five recommendations were made by the pharmacist. Continued review revealed that the report was not dated when it was reviewed and did not indicate if the recommendations were implemented or not.</p> <p>Review of Resident R26's consultant pharmacist medication report, dated August 30, 2024, revealed that two recommendations were made by the pharmacist. Continued review revealed that the report was not dated when it was reviewed and did not indicate if the recommendations were implemented or not.</p> <p>Review of Resident R7's Annual MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], and had diagnoses including anxiety disorder (intense, excessive, persistent worry or fear), depression (mood disorder characterized by low mood, a feeling of sadness, and a general loss of interest in things), psychotic disorder (loss of contact with reality) and end stage renal disease.</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>Review of Resident R7's consultant pharmacist medication report, dated June 3, 2024, revealed that 15 recommendations were made by the pharmacist. Continued review revealed that the report was not dated when it was reviewed and did not indicate if the recommendations were implemented or not.</p> <p>Review of Resident R7's consultant pharmacist medication report, dated August 30, 2024, revealed that four recommendations were made by the pharmacist. Continued review revealed that the report was not dated when it was reviewed and did not indicate if the recommendations were implemented or not.</p> <p>Interview on October 4, 2024, at 1:00 p.m. the Nursing Home Administrator and Director of Nursing confirmed that consultant pharmacist medication reviews were not completed, signed and dated as required for Residents R38, R26, R22, R7 and R13.</p> <p>28 Pa Code 211.9(k) Pharmacy services</p> <p>28 Pa Code 211.12(d)(3) Nursing services</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that a resident was free from unnecessary medications, including the proper use and monitoring of medications, for one of 14 residents reviewed (Resident R45).</p> <p>Findings include:</p> <p>Review of Resident R45's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated September 12, 2024, revealed that the resident was admitted to the facility on [DATE], was in a persistent vegetative state and had diagnoses including hypertension (high blood pressure), seizures (abnormal electrical activity in the brain), anoxic brain damage (brain damage caused by lack of oxygen to the brain) and dependence on ventilator (machines that act as bellows to move air in and out of the lungs).</p> <p>Review of Resident R45's Medication Administration Records (MARs) for September 2024, revealed a physician's order, dated September 6, 2024, for morphine sulfate solution 20 mg (milligrams) per mL (milliliter), give 0.5 mL every four hours as needed for storming (a hyperactive response of the nervous system after severe brain injury that includes increased heart rate, respiratory rate, body temperature, blood pressure, muscle rigidity and spasticity). Continued review revealed that the medication was administered on September 8, 10, 12, 13, 14, 15, 19, 27 and 28, 2024.</p> <p>Review of eMAR (electronic MAR) notes revealed the following:</p> <p>On September 8, 2024, at 5:28 p.m. morphine was administered for neurostorming s/s [signs and symptoms];</p> <p>On September 10, 2024, at 6:37 p.m. morphine was administered for neurostorming relief;</p> <p>On September 12, 2024, at 4:39 p.m. no rationale was provided for why the morphine was administered;</p> <p>On September 13, 2024, at 3:10 p.m. no rationale was provided for why the morphine was administered;</p> <p>On September 14, 2024, at 4:33 p.m. morphine was administered for pain;</p> <p>On September 15, 2024, at 5:32 p.m. morphine was administered for storming;</p> <p>On September 19, 2024, at 4:03 p.m. no rationale was provided for why the morphine was administered;</p> <p>On September 27, 2024, at 8:13 p.m. no rationale was provided for why the morphine was administered; and</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On September 28, 2024, at 10:18 a.m. no rationale was provided for why the morphine was administered.</p> <p>Further review of progress notes for Resident R45 revealed that there were no documented signs or symptoms related to the resident's storming episodes and no documented non-pharmacologic interventions trialed.</p> <p>Interview on October 4, 2024, at 6:54 p.m. the Nursing Home Administrator was unable to explain why there were no documented signs or symptoms of Resident R45's neurostorming or indication of the resident's continued need for morphine.</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343</p> <p>Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed ensure that residents were free from unnecessary psychotropic medications, including the proper use and monitoring of medications, use of as needed medications are limited to 14 days and receiving gradual dose reductions, for two of 14 residents reviewed (Residents R45 and R3).</p> <p>Findings include:</p> <p>Review of facility policy, Psychotropic Medications undated, revealed, Psychotropic medications are drugs that affect brain activities with mental processes and behaviors. Continued review revealed, GDRs [Gradual Dose Reductions] and behavioral interventions will apply for all psychotropics. Further review revealed, PRN [as needed] psychotropic medications are limited to fourteen (14) days . If the prescriber wants the PRN order to be extended, then he/she must document rationale in medical record [and] indicate the duration of the PRN order.</p> <p>Review of Resident R3's clinical record revealed that the resident was admitted to the facility on [DATE]. The resident's diagnoses included Anxiety- Disorder (a mental illness that causes a person to experience excessive and uncontrollable feelings of fear and anxiety), and Delirium (a mental state of confusion, disorientation, and altered awareness that can occur suddenly and is often reversible; Delirium can include changes in thinking, judgment, sleeping patterns, and behavior. People with delirium may appear confused, sleepy, agitated, or withdrawn. They may also have altered beliefs, see hallucinations, or experience emotional changes like anxiety or fear).</p> <p>Review of R3's clinical record revealed a physician order, dated July16, 2024, to give Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate), Give 0.5 tablet by mouth at bedtime for Psychosis. (Psychosis is the term for a collection of symptoms that happen when a person has trouble telling the difference between what's real and what's not).</p> <p>Review of R3's clinical record revealed a physician order, dated November 22, 2023, to monitor for Antipsychotic Medication - Monitor For Dry Mouth, Constipation, Blurred Vision, Disorientation/ Confusion, Difficulty urinating, Hypotension, Dark Urine, Yellow Skin, N/V, Lethargy, Drooling, Symptom s (Tremors, Disturbed Gait, Increased agitation, Restlessness, Involuntary movement of mouth or tongue). Document: 'Y' If monitored And None of the Above observed. 'N' if monitored and any of the above was observed, Select Chart Code 'Other/See Nurses Notes 'and Progress Note Findings Every Day and Night Shift . Review of the Medication Administration Record of R3 indicated that N (No) was marked on several days. Further review of clinical records of R3, did not reveal any document for the Gradual Dose Reduction (GDR) attempt for the Antipsychotic medication.</p> <p>During an interview with the Nursing Home Administrator (NHA), on October 4, 2024, at 2:25 p.m., it was confirmed that no GDR attempt for the Antipsychotic Medication of Resident R3 was available.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R45's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated September 12, 2024, revealed that the resident was admitted to the facility on [DATE], was in a persistent vegetative state and had diagnoses including hypertension (high blood pressure), seizures (abnormal electrical activity in the brain), anoxic brain damage (brain damage caused by lack of oxygen to the brain) and dependence on ventilator (machines that act as bellows to move air in and out of the lungs).</p> <p>Review of Resident R45's Medication Administration Records (MARs) for September 2024, revealed a physician's order, dated September 6, 2024, for lorazepam, give one mg (milligram) every four hours as needed for anxiety (intense, excessive, persistent worry or fear). Continued review revealed that the medication was administered on September 10, 12, 14, 15, 16, 17, 18, 19, 22, 23, 25, 26, 28 and 30, 2024.</p> <p>Review of eMAR (electronic MAR) notes revealed the following:</p> <p>On September 8, 2024, at 10:10 p.m. lorazepam was administered for restlessness;</p> <p>On September 12, 2024, at 2:08 p.m. no rationale was provided for why the lorazepam was administered;</p> <p>On September 14, 2024, at 4:33 p.m. lorazepam was administered for anxiety;</p> <p>On September 15, 2024, at 2:49 p.m. lorazepam was administered for anxiety;</p> <p>On September 16, 2024, at 6:41 p.m. lorazepam was administered for anxiety;</p> <p>On September 17, 2024, at 3:43 p.m. lorazepam was administered for tremors;</p> <p>On September 18, 2024, at 1:53 p.m. lorazepam was administered for visible anxiety;</p> <p>On September 19, 2024, at 2:03 p.m. lorazepam was administered for neuro storming [a hyperactive response of the nervous system after severe brain injury that includes increased heart rate, respiratory rate, body temperature, blood pressure, muscle rigidity and spasticity];</p> <p>On September 19, 2024, at 8:51 p.m. no rationale was provided for why the lorazepam was administered;</p> <p>On September 22, 2024, at 2:11 p.m. no rationale was provided for why the lorazepam was administered;</p> <p>On September 23, 2024, at 12:45 p.m. no rationale was provided for why the lorazepam was administered;</p> <p>On September 23, 2024, at 7:46 p.m. lorazepam was administered for c/o [complaint of] pain;</p> <p>On September 25, 2024, at 5:15 p.m. no rationale was provided for why the lorazepam was administered;</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On September 26, 2024, at 2:34 a.m. no rationale was provided for why the lorazepam was administered;</p> <p>On September 26, 2024, at 5:10 p.m. no rationale was provided for why the lorazepam was administered;</p> <p>On September 28, 2024, at 10:19 a.m. no rationale was provided for why the lorazepam was administered;</p> <p>On September 28, 2024, at 7:46 p.m. no rationale was provided for why the lorazepam was administered; and</p> <p>On September 30, 2024, at 1:08 p.m. no rationale was provided for why the lorazepam was administered.</p> <p>Further review of progress notes for Resident R45 revealed that there were no documented signs or symptoms related to the resident's anxiety and no documented non-pharmacologic or behavioral interventions trialed. There was no documented rationale or duration noted for why the use of the medication continued beyond 14 days, as required.</p> <p>Interview on October 4, 2024, at 6:54 p.m. the Nursing Home Administrator was unable to explain why Resident R45's lorazepam was not evaluated by the physician for use beyond 14 days.</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12(d)(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>39343</p> <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observations, review of clinical records, and interviews with facility staff, it was determined that the facility failed to ensure that it was free of medication error rate of five percent or greater for one of four residents observed during medication administration (Resident R7).</p> <p>Findings include:</p> <p>On October 2, 2024, at 9:49 a.m., observed that Employee E4, a Licensed Nurse, administered to Resident R7, the medicine, Vitamin B Complex, (which has no Vitamin C) tablet.</p> <p>Review of physician order dated June 2, 2024, for Resident R7, revealed an order to administer Nephro-Vite Rx Oral Tablet 1 MG (B-Complex with C & Folic Acid), Give 1 tablet by mouth in the morning for Renal Deficiency.</p> <p>At the time of the observation, interview with Licensed Nurse, E4, confirmed the above findings.</p> <p>On October 2, 2024, at 9:49 a.m., observed that Employee E4, a Licensed Nurse, administered to Resident R7, 5 ml of Ferrous Sulfate Syrup 220 MG/5ML (which equals 220 MG).</p> <p>Review of physician order dated June 2, 2024, for Resident R7, revealed an order to administer Ferrous Sulfate Syrup 300 (60 Fe) MG/5ML, Give 5 ML by mouth one time a day for Anemia to equal 300 MG.</p> <p>At the time of the observation, interview with Licensed Nurse, E4, confirmed the above findings.</p> <p>The facility incurred a medication error rate of 7.14%.</p> <p>Pa Code:211.12(d)(1)(2)(5) Nursing Services.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>48347</p> <p>Based on review of clinical records and interview with residents and staff it was determined that the facility failed to routinely offer evening snacks as desired by two of two oriented residents (R21 and R7).</p> <p>Findings include:</p> <p>Review of facility policy titles Mealtimes revealed that the facility provides mealtime is breakfast is served between 8:15 a.m. and 8:30 a.m., lunch is served between 12:15 p.m. and 12:30p.m. and dinner is served between 4:45 p.m. and 5:15 p.m.</p> <p>Interview was held on October 2, 2024 at 1:10p.m. with Resident R21 revealed that snacks were not routinely offered in the evenings and that they would like to receive an evening snack.</p> <p>Interview with Employee E 12 revealed that snacks are always available for all residents and some residents have orders for snacks.</p> <p>Interview on October 1, 2024, at 11:17 a.m. Resident R7 stated that she likes eating snacks, that her family has to bring them in for her because the facility only offers snacks every once in a while and that the facility does not offer her any snacks at bedtime. Observation, at the time of the interview, Resident R7 was eating a package of peanut butter crackers and stated that her family brought it in for her.</p> <p>28 Pa. Code 211.12 (d)(1)Nursing services</p>		

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<p>F 0838</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>39344</p> <p>Based on review of professional literature, facility documentation and interviews with staff, it was determined that the facility failed to conduct a facility-wide assessment, using evidence-based methods, that included staff education and competency requirements as well as active involvement from all required participants, as required.</p> <p>Findings include:</p> <p>Review of the Centers for Medicare and Medicaid Services Memorandum, Revised Guidance for Long-Term Care Facility Assessment Requirements (QSO-24-13-NH) dated June 18, 2024, revealed that the facility assessment must include an evaluation of diseases, conditions, physical or cognitive limitations of the resident population, acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions) and any other pertinent information about the resident population as a whole that may affect the services the facility must provide. Continued review revealed, The assessment of the resident population should drive staffing decisions and inform the facility about what skills and competencies staff must possess in order to deliver the necessary care required by the residents being served. Further review revealed, In conducting the facility assessment, the facility must ensure active involvement from key individuals such as the facility's leadership, and direct care staff (e.g., nurses), and also solicit input from residents and families.</p> <p>Review of the facility's Resident Matrix, dated October 4, 2024, revealed that 40 residents required tracheostomy (a surgically created hole in your trachea that allows for breathing) care, 22 residents required ventilator (machines that act as bellows to move air in and out of the lungs) care, 36 residents required tube feedings, 12 residents had pressure ulcers, seven residents required dialysis (the process of removing waste products and excess fluid from the body; dialysis is necessary when the kidneys are not able to adequately filter the blood), 12 residents had urinary catheters, three residents required intravenous therapy and two residents had physical restraints.</p> <p>Review of the Facility Assessment, dated last reviewed September 2024, revealed that the facility evaluates annually the educational needs including competencies that are needed for our staff. During this evaluation, the facility produces a list of educations and competencies that are needed annually. Continued review revealed, The facility holds a structured orientation for new hires. During this orientation the staff receive education and competencies on the necessary requirements.</p> <p>Further review of the Facility Assessment revealed that there was no indication of the specific trainings or skills competencies required to meet the needs of the resident population. There was no indication of any evidence-based, data-driven methods used to determine the care needs of the residents. There was no indication that the facility ensured involvement from direct care staff, including licensed nurses and nurse aides, residents, resident representatives and family members.</p> <p>Interview on October 4, 2024, at 6:54 p.m. the Nursing Home Administrator confirmed that the Facility Assessment did not contain all of the required information.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on observations, review of facility policies and documents, clinical record reviews and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related to enhanced barrier precautions for three of eight of infection surveillance, water management, infection data reporting and infection committee meetings, as required. (Resident 22, Resident 24 and Resident 19)</p> <p>Findings include:</p> <p>Review of facility policy, Infection Prevention and Control Manual dated June 13, 2024, revealed that the Infection Control Committee has the authority to implement effective measures for the detection, surveillance, control and prevention of healthcare associated infections. Infection Committee meetings are scheduled quarterly and the Committee recommends actions based on evaluation of the surveillance records and reports of infections. Continued review revealed that all healthcare associated infections that meet the McGeers criteria (used to assess infections) will be reported to the Pennsylvania Patient Safety Reporting System (PA-PSRS) [Act 52 of 2007 mandates that nursing homes develop and implement comprehensive infection control plans and reporting of healthcare-associated infections as serious events. The PA-PSRS was created as a system for facilities to submit the required information]. The facility will provide written notification to residents or their representatives within seven days of all healthcare associated infections. Further review revealed that the facility will collaborate with Maintenance Mangers for its water management program which includes an interdisciplinary team, description and diagram of the water system and identification of areas in the water system that could encourage growth of water-borne illnesses.</p> <p>Review of Center for Disease control CDC guidelines https://www.cdc.gov/long-term-care-facilities/about/index.html revealed that A risk-based approach to personal protective equipment (PPE) use designed to reduce the spread of multidrug-resistant organisms (MDROs) The use of gown and gloves during high-contact resident care activities for residents at high risk of colonization with an MDRO(multi drug resistant organisms) to disrupt spread. Enhanced barrier precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and used in coordination with good infection prevention and control measures. Enhanced Barrier precaution are to be used during activities of dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting device care or use with Indwelling catheter, tracheostomy, ventilator, central line ,feeding tube, and wound care. Generally defined as the care of any skin opening.</p> <p>Review of Resident R24's Quarterly Minimum data set (MDS- a federal mandated assessment tool used to evaluate nursing home residents) dated September 9, 2024 revealed that Resident R24 was admitted into the facility August 11, 2023 with diagnosis including of Neurogenic bladder(bladder dysfunction), respiratory failure (respiratory system fails from inadequate gas exchange by the respiratory system) stroke (lack of blood flow to the brain causing cell death), and seizure disorder (a sudden uncontrollably electrical activity in the brain temporary effects consciousness, muscle control and behavior). Further review of Resident R24's MDS revealed that Resident R24 required a urinary indwelling catheter and enteral feeding (feeding tube).</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 - Many</p>	<p>Observation of Resident R24's room October 1, 2024 at 10:30 a.m. revealed signage at the door indicating Enhanced Barrier Precautions.</p> <p>Observation on October 1, 2024 at 10:45 a.m. revealed respiratory therapist, Employee E6 providing respiratory care to Resident R24. Employee E6 was wearing mask and gloves and no gown. Employee E6 stated that personal protective equipment (PPE) was not required, only mask and gloves.</p> <p>Review of Resident R22's quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident R22 was admitted into the facility September 19, 2023, with diagnosis of septicemia (a bloodstream infection), pneumonia (inflammation and fluids in the lungs caused by bacteria, viral, or fungal infections), and respiratory failure (respiratory system fails from inadequate gas exchange by the respiratory system) stroke (lack of blood flow to the brain causing cell death). Further review of Resident R22's MDS revealed that Resident R 22 required enteral feeding.</p> <p>Observation on October 1, 2024 at 11:27 a.m. revealed nurse aide, Employee E7 providing care to Resident R22 only wearing gloves.</p> <p>Review of Resident R19's admission MDS dated [DATE] revealed Resident R19 was admitted into the facility July 8, 2024 with diagnosis including traumatic brain injury and seizure disorder.</p> <p>Review of Resident R19's Admission Minimum Data Set (MDS) dated [DATE] revealed that Resident R19, was admitted into the facility on [DATE] with diagnosis of traumatic brain injury and seizure disorder (a sudden uncontrollably electrical activity in the brain temporary effects consciousness, muscle control and behavior). Further review of Resident R19's MDS revealed that Resident R24 require enteral feeding.</p> <p>Observation of Resident R19's room October 1, 2024 at 10:48 a.m. revealed signage at the door indicating Enhanced Barrier Precautions Continued observation during medication administration revealed that Licensed nurse, Employee E8 was wearing gloves and mask but no gown. The resident required medication administered through tube feeding.</p> <p>Review of infection control and surveillance data for June 2024, revealed that an infection committee meeting was held on July 10, 2024, and that Nursing Home Administrator was the only person in attendance at the meeting. The committee meeting minutes contained no data related to needed areas of improvement; surveillance measures including hand hygiene, personal protective equipment, linens, environmental disinfecting, meal trays, clinical practice, outbreaks and disease reporting; vaccinations, exposure to communicable diseases, antibiotic stewardship program, policies, water management program and education. Continued review of infection control and surveillance data for June 2024, revealed that there were no infection tracking or surveillance logs completed.</p> <p>Review of infection control and surveillance data for July 2024, revealed that an infection committee meeting was held on August 5, 2024, and did not have all of the required members at the meeting. The committee meeting minutes contained no data related to needed areas of improvement; surveillance measures including hand hygiene, personal protective equipment, linens, environmental disinfecting, meal trays, clinical practice, outbreaks and disease reporting; vaccinations, exposure to communicable diseases, antibiotic stewardship program, policies, water management program and education. Continued review of infection control and surveillance data for July 2024, revealed that there were no infection tracking or surveillance logs completed.</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 - Many</p>	<p>Review of infection control and surveillance data for August 2024, revealed that an infection committee meeting was held on September 30, 2024, and did not have all of the required members at the meeting. The committee meeting minutes contained no data related to needed areas of improvement; surveillance measures including hand hygiene, personal protective equipment, linens, environmental disinfecting, meal trays, clinical practice, outbreaks and disease reporting; vaccinations, exposure to communicable diseases, antibiotic stewardship program, policies, water management program and education. Continued review of infection control and surveillance data for August 2024, revealed that there were no infection tracking or surveillance logs completed.</p> <p>Interview on October 2, 2024, at 1:10 p.m. the Nursing Home Administrator and Employee E27, Infection Preventionist, revealed that there was no PA-PSRS data available for review at the time of the survey due to no one at the facility had access to the PA-PSRS system.</p> <p>On October 3, 2024, at 1:51 p.m. Employee E27, Infection Preventionist provided the facility's Enhanced Barrier Precautions policy. The policy did not contain a title, facility name, policy statement or application to the needs of the resident population. Employee E27, Infection Preventionist, stated that the policy was just pulled from the CDC [Centers for Disease Control] website and confirmed that it was not incorporated into a facility policy or include how it meets the needs of the residents at the facility.</p> <p>Interview on October 4, 2024, at 6:54 p.m. the Nursing Home Administrator confirmed that the facility did not have a water management plan that was specific to the analysis and monitoring of the water system at the facility.</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p> <p>28 Pa Code 201.18(d) Management</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>39344</p> <p>Based on review of facility policies and documentation, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to maintain an effective antibiotic stewardship program for two of three of residents reviewed for antibiotics (Residents R38 and R26).</p> <p>Findings include:</p> <p>Review of facility policy, Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes undated, revealed, Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance form. Continued review revealed that the Infection Preventionist will review all antibiotic starts within 48 hours to determined if continued therapy is justified, justified with needed intervention, or not justified. Further review revealed, At the conclusion of the review, the provider will be notified of the review findings and recommendations. His or her response will be documented.</p> <p>Review of Medication Administration Records (MARs) for Resident R26 revealed a physician's order, dated September 18, 2024, for Cefpodoxime (antibiotic medication) for urinary tract infection for ten days. The MARs indicated that the medication was administered from September 18 through 27, 2024.</p> <p>Continued review of MARs for Resident R26 revealed a physician's order, dated September 26, 2024, for Bactrim (antibiotic medication) for prophylaxis until October 2, 2024. The MARs indicated that the medication was administered from September 26 through October 2, 2024.</p> <p>Review of facility documentation Infection Report dated September 26, 2024, revealed that Resident R26 was started on Bactrim for a facility acquired infection for prophylaxis. There was no clinical indication for why the antibiotic was initiated, what infection or symptoms the medication was used to treat or if the antibiotic was reviewed within 48 hours for continued appropriate use. There was no indication of when the report was completed. Continued review of facility documentation revealed that no Infection report was completed for Resident R26's use of Cefpodoxime.</p> <p>Review of MARs for Resident R38 revealed a physician's order, dated September 6, 2024, for Levaquin (antibiotic medication) for leukocytosis (elevated white blood cells) every two days for seven days. The MARs indicated that the medication was administered from September 6 through 12, 2024.</p> <p>Review of facility documentation Infection Report dated September 6, 2024, revealed that Resident R38 was started on Levaquin for two days for a facility acquired infection for leukocytosis and pneumonia (lung infection). There was no date on when the report was completed or if the prescribed antibiotic was reviewed within 48 hours.</p> <p>Further review of facility documentation revealed that there were no infection tracking or surveillance logs completed that included Residents R26 and R38's infections and antibiotic usage.</p> <p>Interview on October 3, 2024, at 1:51 p.m. Employee E27, Infection Preventionist, confirmed that antibiotic tracking and reporting data was not properly completed for Residents R26 and R38.</p> <p>(continued on next page)</p>

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(d) Management

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344</p> <p>Based on clinical record reviews and interviews with staff, it was determined that the facility failed to offer influenza and pneumococcal vaccines for five of five residents reviewed for vaccinations (Residents R43, R38, R2, R44 and R12).</p> <p>Findings include:</p> <p>Review of facility policy, Pneumococcal/COVID Vaccine Guidelines dated September 1, 2024, revealed, All residents will be offered the pneumococcal and COVID vaccines to aid in preventing pneumococcal and COVID infections. Continued review revealed, Each resident or the resident's authorized representative will receive education regarding the benefits and potential side effects of the vaccine.</p> <p>Review of facility policy, Influenza Vaccine undated, revealed that all residents will be offered the influenza vaccine annually. Continued review revealed, The facility shall provide pertinent information about the significant risks and benefits of vaccines to . residents.</p> <p>Clinical record review for Resident R43 revealed that the resident was admitted to the facility on [DATE]. Continued review revealed that there was no indication in Resident R43's clinical record that the resident was offered the pneumococcal vaccine.</p> <p>Clinical record review for Resident R38 revealed that the resident was admitted to the facility on [DATE]. Continued review revealed that there was no indication in Resident R38's clinical record that the resident was offered the pneumococcal vaccine.</p> <p>Clinical record review for Resident R2 revealed that the resident was admitted to the facility on [DATE]. Continued review revealed that there was no indication in Resident R2's clinical record that the resident was offered the pneumococcal vaccine.</p> <p>Clinical record review for Resident R44 revealed that the resident was admitted to the facility on [DATE]. Continued review revealed that there was no indication in Resident R44's clinical record that the resident was offered the pneumococcal vaccine.</p> <p>Clinical record review for Resident R12 revealed that the resident was admitted to the facility on [DATE]. Continued review revealed that there was no indication in Resident R12's clinical record that the resident was offered the influenza or pneumococcal vaccines.</p> <p>Further clinical review for Residents R43, R38, R2, R44 and R12 revealed no evidence that the residents or their responsible parties received education regarding the benefits and potential side effects of the vaccines.</p> <p>Interview on October 4, 2024, at 6:54 p.m. the Nursing Home Administrator confirmed that there was no indication that vaccines or education regarding the vaccines were provided to Residents R43, R38, R2, R44 and R12.</p> <p>28 Pa Code 201.18(b)(1) Management</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396143	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER Aristacare at East Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 Henry Avenue, 7th Floor Philadelphia, PA 19129	

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa Code 201.18(d) Management</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 39344</p> <p>Based on clinical record reviews and interviews with staff, it was determined that the facility failed to offer COVID vaccines for three of five residents reviewed for vaccinations (Residents R43, R38 and R44).</p> <p>Findings include:</p> <p>Review of facility policy, Pneumococcal/COVID Vaccine Guidelines dated September 1, 2024, revealed, All residents will be offered the pneumococcal and COVID vaccines to aid in preventing pneumococcal and COVID infections. Continued review revealed, Each resident or the resident's authorized representative will receive education regarding the benefits and potential side effects of the vaccine.</p> <p>Clinical record review for Resident R43 revealed that the resident was admitted to the facility on [DATE]. Continued review revealed that there was no indication in Resident R43's clinical record that the resident was offered the COVID vaccine.</p> <p>Clinical record review for Resident R38 revealed that the resident was admitted to the facility on [DATE]. Continued review revealed that there was no indication in Resident R38's clinical record that the resident was offered the COVID vaccine.</p> <p>Clinical record review for Resident R44 revealed that the resident was admitted to the facility on [DATE]. Continued review revealed that there was no indication in Resident R44's clinical record that the resident was offered the COVID vaccine.</p> <p>Further clinical review for Residents R43, R38 and R44 revealed no evidence that the residents or their responsible parties received education regarding the benefits and potential side effects of the vaccines.</p> <p>Interview on October 4, 2024, at 6:54 p.m. the Nursing Home Administrator confirmed that there was no indication that vaccines or education regarding the vaccines were provided to Residents R43, R38 and R44.</p> <p>28 Pa Code 201.18(b)(1) Management</p> <p>28 Pa Code 201.18(d) Management</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>39344</p> <p>Based on review of personnel files, facility documentation and interviews with staff, it was determined that the facility failed to ensure that an effective training program was maintained as required for nine of 13 staff reviewed (Employees E22, E10, E23, E24, E28, E29, E30, E31 and E32).</p> <p>Findings include:</p> <p>Review of the Facility Assessment, dated last reviewed September 2024, revealed that the facility evaluates annually the educational needs including competencies that are needed for our staff. During this evaluation, the facility produces a list of educations and competencies that are needed annually. Continued review revealed, The facility holds a structured orientation for new hires. During this orientation the staff receive education and competencies on the necessary requirements. Further review of the Facility Assessment revealed that there was no indication of the specific trainings required for staff to meet the needs of the resident population.</p> <p>Review of Employee E22's personnel file revealed that the employee was hired by the facility on August 14, 2024, as a registered nurse.</p> <p>Review of Employee E10's personnel file revealed that the employee was hired by the facility on August 1, 2024, as a licensed practical nurse.</p> <p>Review of Employee E23's personnel file revealed that the employee was hired by the facility on August 15, 2024, as a nurse aide.</p> <p>Review of Employee E24's personnel file revealed that the employee was hired by the facility on August 12, 2024, as a nurse aide.</p> <p>Review of Employee E28's personnel file revealed that the employee was hired by the facility on August 28, 2018, as a nurse aide.</p> <p>Review of Employee E29's personnel file revealed that the employee was hired by the facility on June 13, 2019, as a unit clerk.</p> <p>Review of Employee E30's personnel file revealed that the employee was hired by the facility on September 3, 2020, as a licensed practical nurse.</p> <p>Review of Employee E31's personnel file revealed that the employee was hired by the facility on June 10, 2021, as a nurse aide.</p> <p>Review of Employee E32's personnel file revealed that the employee was hired by the facility on August 10, 2022, as a nurse aide.</p> <p>(continued on next page)</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Further review of personnel files for Employees E22, E10, E23 and E24 revealed that there was no indication that the employee received any orientation trainings upon hire, such as communication, residents rights, dementia management, quality assurance, infection control, compliance and ethics, behavioral health, accident prevention, restorative nursing techniques, emergency preparedness, fire prevention and safety cultural competency.</p> <p>Further review of personnel files for Employees E28, E29, E30, E31 and E32 revealed that there was no indication that the employee received any annual trainings, such as communication, residents rights, dementia management, quality assurance, infection control, compliance and ethics, behavioral health, accident prevention, restorative nursing techniques, emergency preparedness, fire prevention and safety cultural competency.</p> <p>Interview on October 4, 2024, at 6:54 p.m. the Nursing Home Administrator revealed that there were no training records for Employees E22, E10, E23, E24, E28, E29, E30, E31 and E32 available for review at the time of the survey.</p> <p>28 Pa Code 201.19(7) Personnel policies and procedures</p> <p>28 Pa Code 201.20(a)(1-6) Staff development</p> <p>28 Pa Code 201.20(b) Staff development</p> <p>28 Pa Code 201.20(d) Staff development</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>39344</p> <p>Based on review of personnel files and interviews with staff, it was determined that the facility failed to ensure that nurse aides received at least 12 hours of continuing education per year as required for three of five nurse aide personnel files reviewed (Employees E28, E31 and E32).</p> <p>Findings include:</p> <p>Review of Employee E28's personnel file revealed that the employee was hired by the facility on August 28, 2018, as a nurse aide.</p> <p>Review of Employee E31's personnel file revealed that the employee was hired by the facility on June 10, 2021, as a nurse aide.</p> <p>Review of Employee E32's personnel file revealed that the employee was hired by the facility on August 10, 2022, as a nurse aide.</p> <p>Further review of personnel files for Employees E28, E31 and E32 revealed that there was no evidence that the employees completed at least 12 hours of continuing education per year as required.</p> <p>Interview on October 4, 2024, at 6:54 p.m. the Nursing Home Administrator revealed that there were no continuing education records for Employees E28, E31 and E32 available for review at the time of the survey.</p> <p>28 Pa Code 201.19(7) Personnel policies and procedures</p> <p>28 Pa Code 201.20(d) Staff development</p>		