

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  396145	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2024
NAME OF PROVIDER OR SUPPLIER  Menno Haven Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2055 Scotland Avenue Chambersburg, PA 17201	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>48809</p> <p>Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the physician was notified timely about a change in condition for one of 16 residents reviewed (Resident 11).</p> <p>Findings include:</p> <p>The facility's policy regarding notification of changes, dated June 12, 2024, revealed that the physician was to be notified with any changes in a resident's condition.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 11, dated July 11, 2024, indicated that the resident was understood and could understand, was cognitively intact, required substantial assistance for care, was receiving a diuretic medication (a drug that causes increased urine output), and had diagnoses that included end-stage kidney disease. A care plan for Resident 11, dated July 5, 2024, revealed that the resident was on a diuretic for high blood pressure and required daily monitoring for effectiveness. Physician's orders for Resident 11, dated July 12, 2024, included an order for the resident to have daily weights taken.</p> <p>Review of Resident 11's clinical record revealed that on July 31, 2024, the resident weighed 204 pounds, and on August 1, 2024, the resident weighed 216.8 pounds (a 12.8-pound increase).</p> <p>There was no documented evidence that the physician was notified of Resident 11's weight gain of 12.8 pounds in one day.</p> <p>Interview with RN Clinical Manager 1 on August 6, 2024, at 3:28 p.m. confirmed that there was no documented evidence that Resident 11's physician was notified about the 12.8 pound weight gain, and that it should have been addressed.</p> <p>28 Pa. Code 211.12(d)(3) Nursing Services.</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 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>31760</p> <p>Based on review of facility policies, clinical records, and observations, as well as staff interviews, it was determined that the facility failed to ensure that a baseline care plan was developed and implemented for one of 16 residents reviewed (Resident 50).</p> <p>Findings include:</p> <p>The facility's policy regarding baseline care plans (includes the minimum healthcare information necessary to properly care for a resident), dated June 12, 2024, indicated that the baseline care plan will be developed within 48 hours of a guest's admission, include the minimum healthcare information necessary to properly care for the guest including, but not limited to: initial goals based on admission orders, physician's orders, dietary orders, therapy orders, and social services. The admitting nurse or supervising nurse on duty shall gather information from the admission physical assessment, hospital transfer information, physician's orders, and discussion with the guest and the guest's representative. Interventions shall be initiated that address the guest's current needs.</p> <p>A nursing note for Resident 50, dated August 2, 2024, indicated that the resident was admitted to the facility that day.</p> <p>Physician's orders for Resident 50, dated August 2, 2024, included an order for the resident to have an indwelling urinary catheter (a medical device that drains urine from the bladder), provide indwelling urinary catheter care every day and night shift, change the indwelling urinary catheter drainage bag every two weeks on Friday, change the indwelling urinary catheter every 28 days, and irrigate the indwelling urinary catheter with 60 milliliters (ml) of sterile water as needed for blockage.</p> <p>Physician's orders for Resident 50, dated August 2, 2024, included an order for the resident to be on Enhanced Barrier Precautions (an infection control intervention designed to reduce transmission of resistant organisms).</p> <p>Observations of Resident 50 on August 5, 2024, at 2:11 p.m. and on August 6, 2024, at 2:35 p.m. revealed that the resident had an Enhanced Barrier precaution sign on her doorway indicating that the resident was on Enhanced Barrier Precautions, and she was in her room sitting her wheelchair with a indwelling urinary catheter drainage bag hanging from underneath her wheelchair.</p> <p>There was no documented evidence that Resident 50's baseline care plan, dated August 2, 2024, included information about the resident's care needs related to the indwelling urinary catheter and Enhanced Barrier Precautions.</p> <p>Interview with the Nursing Home Administrator on August 7, 2024, at 10:15 a.m. confirmed that there was no documented evidence that a baseline care plan was developed and implemented related to Resident 50's indwelling urinary catheter and Enhanced Barrier Precautions.</p> <p>28 Pa. Code 211.12(d)(3)(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>31760</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs for two of 16 residents reviewed (Residents 17, 29).</p> <p>Findings include:</p> <p>The facility's policy regarding comprehensive care plans, dated June 12, 2024, indicated that the interdisciplinary team, in conjunction with the guest and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each guest. The comprehensive, person-centered care plan will include measurable objectives and timeframes and describe the services that are to be furnished to attain or maintain the guest's highest practicable physical, mental, and psychological well-being.</p> <p>An admission MDS assessment for Resident 17, dated July 4, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included dementia. A care plan for the resident, dated June 28, 2024, and resolved on July 3, 2024, revealed that the resident used continuous positive airway pressure (CPAP - a machine that uses mild air pressure to keep breathing airways open while sleeping) related to obstructive sleep apnea (when breathing is interrupted during sleep).</p> <p>Physician's orders for Resident 17, dated July 17, 2024, included an order for staff to apply the resident's CPAP in the p.m. and remove the resident's CPAP in the a.m.</p> <p>There was no documented evidence that an individualized care plan was developed and implemented again related to Resident 17's CPAP.</p> <p>Interview with the Nursing Home Administrator on August 7, 2024, at 10:15 a.m. revealed that Resident 17's care plan was resolved because he was not using the CPAP, and then his wife talked him into using the CPAP again. He confirmed that a care plan should have been developed regarding the resident's CPAP.</p> <p>An admission MDS assessment for Resident 29, dated July 21, 2024, revealed that the resident was understood and could understand others.</p> <p>A nursing note for Resident 29, dated July 22, 2024, revealed that the writer found Halls cough drops in the resident's room. The resident insisted on having cough drops at his bedside and can appropriately administer the medication. A new order was obtained for the cough drops, and that he may have them at his bedside</p> <p>Physician's orders for Resident 29, dated July 22, 2024, included an order for the resident to receive cough drops mouth/throat lozenges as needed for cough and may do unsupervised self-administration.</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>There was no documented evidence that an individualized care plan was developed and implemented related to Resident 29's ability to self-administer the cough drops or have the cough drops at his bedside.</p> <p>Interview with Nursing Home Administrator on August 6, 2024, at 2:15 p.m. confirmed that Resident 29's care plan was not developed until today for the self-administration of the cough drops and to have the cough drops at his bedside.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>48809</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that physician orders were followed for one of 16 residents reviewed (Resident 11).</p> <p>Findings include:</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 11, dated July 11, 2024, revealed that the resident was cognitively intact, depended on assistance from staff for daily care needs, and received a diuretic (a medication that increases urine output). A care plan, dated July 5, 2024, indicated that the resident was to receive diuretic per physician's orders.</p> <p>Physician's orders for Resident 11, dated July 29, 2024, included an order for the resident to receive 2 milligrams (mg) of Bumex (a diuretic) every 24 hours as needed for edema (swelling), if the resident has a 2-pound weight increase in one day.</p> <p>A review of Resident 11's Treatment Administration Record (TAR) for July and August 2024 revealed that the resident's weight on July 30 was 202 pounds, July 31 was 204 pounds, and August 1 was 216.8 pounds.</p> <p>A review of Resident 11's Medication Administration Record (MAR) for July and August 2024 revealed that the resident did not receive Bumex on July 31 for a 2-pound weight gain or on August 1 for a 12.8-pound weight gain.</p> <p>Interview with RN Clinical Manager 1 on August 6, 2024, at 15:28 p.m. confirmed that Resident 11 did not receive Bumex as ordered and should have on the above dates.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41233</p> <p>Based on review of policies, observations, and staff interviews, it was determined that the facility failed to ensure that food was thawed as per facility policy and that food stored in the kitchen was labeled, dated and secured.</p> <p>Findings include:</p> <p>The facility's policies regarding thawing frozen foods and food storage, dated June 12, 2024, revealed that food should never be thawed at room temperature and any food that has been opened must be labeled, dated and secured in such a way that the food item is air tight.</p> <p>Observations in the kitchen on August 5, 2024, at 10:23 a.m. revealed that there was a total of 38 hot dogs thawing on the counter at room temperature.</p> <p>Observations in the walk-in cooler on August 5, 2024, at 10:27 revealed that there was approximately one cup of sage in a plastic bag that was undated and unsecured.</p> <p>Observations in the meat cooler on August 5, 2024, at 10:30 a.m. revealed that there was one piping bag (a kitchen tool in the shape of a cone used for decorating cakes, pies and pastries) full of whip cream that was undated and unsecured.</p> <p>Observations in dry storage on August 5, 2024, at 10:34 a.m. revealed that there was approximately three pounds of dry spaghetti secured in plastic wrap but undated.</p> <p>Interview with the Director of Dietary and the Executive Director of Culinary on August 5, 2024, at 10:45 a.m. confirmed that food should not be thawing on the counter at room temperature and all food items in the kitchen should be labeled, dated and secured.</p> <p>28 Pa. Code 211.6(f) Dietary Services.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28177</p> <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for three of 16 residents reviewed (Residents 11, 26, 29).</p> <p>Findings Include:</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 11, dated June 11, 2024, revealed that the resident was understood, could understand others, and had diagnoses that included a hip fracture. A care plan for the resident, dated July 5, 2024, revealed that the resident was on a Restorative Nursing Program for active range of motion, and the resident was to perform 15 ankle pumps (bend foot up and down at the ankle joint) and 15 ankle rolls (roll ankle to the right in a circular motion, and then to the left in a circular motion) two times per day.</p> <p>Review of nurse aide documentation for Resident 11, dated July and August 2024, revealed that staff documented the 15 ankle pumps and the 15 ankle rolls as Not Applicable (NA) during the day shift on July 24, 25, 26, 28, and August 1, 2, and 6, 2024.</p> <p>An admission MDS assessment for Resident 26, dated June 25, 2024, revealed that the resident was usually understood, could understand others, and had a diagnosis which included cerebral vascular accident (CVA - commonly known as a stroke). A care plan for the resident, dated June 11, 2024, revealed that the resident was on a Restorative Nurse Program for active range of motion, and the resident was to perform 15 ankle pumps (bend foot up and down at the ankle joint) and 15 ankle rolls (roll ankle to the right in a circular motion, and then to the left in a circular motion) two times per day.</p> <p>Review of nurse aide documentation for Resident 26, dated June, July, and August 2024, revealed that staff documented the 15 ankle pumps and the 15 ankle rolls as NA during the day shift on June 22, 23, and 28, 2024, and was left blank on June 26, and 29, and August 2, 2024.</p> <p>Review of nurse aide documentation for Resident 26, dated June, July, and August 2024, revealed that staff documented the 15 ankle pumps and the 15 ankle rolls as NA during the night shift on June 20-25, 27-30; July 1, 3, 5, 6, 7, 10, 11, 14, 17, 18, 19, 22, 24, 26, 27, 28, 30 and 31; and August 2, 3, 4, 2024, and was left blank on June 26, and July 8, 13, 15, 21, and 23, 2024.</p> <p>An admission MDS assessment for Resident 29, dated July 21, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included a hip fracture. A care plan for the resident, dated July 16, 2024, revealed that the resident was on a Restorative Nurse Program for active range of motion, and the resident was to perform 15 ankle pumps (bend foot up and down at the ankle joint) and 15 ankle rolls (roll ankle to the right in a circular motion, and then to the left in a circular motion) two times per day.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of nurse aide documentation for Resident 29, dated July and August 2024, revealed that staff documented the 15 ankle pumps, and the 15 ankle rolls as NA during the night shift on July 17, 19, 26, 27, 28, 30 and 31, and August 2, 2024, and was left blank on July 23, 2024.</p> <p>Interview with the Nursing Home Administrator on August 7, 2024, at 8:55 a.m. regarding Residents 11, 26 and 29 confirmed that staff should be documenting that the resident received, did not receive, or refused, and that staff should not be documenting NA or leaving blank spaces.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>48809</p> <p>Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficient practices.</p> <p>Findings include:</p> <p>The facility's deficiencies and plans of correction for State Survey and Certification (Department of Health) survey ending September 7, 2023, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending August 7, 2024, identified repeated deficiencies related to quality of care and sanitary food preparation and storage.</p> <p>The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending September 7, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding quality of care.</p> <p>The facility's plan of correction for a deficiency regarding proper food preparation and storage, cited during the survey ending September 7, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F812, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding maintaining proper food preparation and storage.</p> <p>Refer to F684, F812.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>		