

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Spiritrust Lutheran the Village at Luther Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 2781 Luther Drive Chambersburg, PA 17202	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>37116</p> <p>Based on policy review, review of facility investigation documentation, and staff interviews, it was determined that the facility failed to ensure that all alleged violations involving abuse were reported immediately for one of one resident abuse reports reviewed (Resident 38).</p> <p>Findings include:</p> <p>Review of facility policy, titled Abuse/Neglect Exploitation Prevention Standard for Skilled Care, revised October 4, 2017, revealed, Allegations of abuse or neglect may be reported by any individual having knowledge of or perceiving that a situation of abuse, exploitation or neglect has occurred. Team members working in the retirement communities are considered 'mandatory' reporters. Allegations in the skilled center will be reported to the skilled care center administrator, Director of Nursing, or designee immediately.</p> <p>Review of facility's electronic incident report submission and associated documents, dated March 25, 2024, revealed that it was reported by Employee 3 that while Employees 3 and 4 (Nurse Aides) were providing care to Resident 38 on March 21, 2024, Resident 38 was screaming uncontrollably in anxiety, and Employee 4 said to Resident 38 in her ear with aggression Stop yelling, there are people out there in dining room trying to eat! Did you care when you had them up all the night before that they are tired? Employee 4 then took a wash cloth and at least twice ran it over Resident 38's face in an attempt to hush her. When Resident 38 began to scream more, Employee 4 placed her fingers in the resident's mouth and then nose while mocking the Resident's noises and voice. Further review of the incident report submission revealed that following Employee 3's report of alleged abuse, a second staff member, Employee 6 (Nurse Aide), reported an additional allegation of abuse that occurred on March 18, 2024, where Employee 4 sprayed Resident 38 in the face with water during her bath.</p> <p>Review of Employee 5's (Registered Nurse Supervisor) witness statement dated March 24, 2024, revealed that Employee 3 reported the alleged incident that occurred on March 21, 2024, to her on March 24, 2024. Further review of Employee 5's witness statement revealed that Employee 6 also came to her on that date and reported a separate incident involving Employee 4 and Resident 38.</p> <p>Review of Employee 6's witness statement, dated March 24, 2024, revealed that on March 18, 2024, around 10:00 AM, she and Employee 4 were bathing Resident 38. Resident 38 was worked up but nothing different than usual. Employee 4 was visually and vocally frustrated with Resident 38 and her behavior. Employee 4 used the handle sprayer twice to spray Resident 38 in the face.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing on July 25, 2024, at 1:55 PM, she revealed the expectation that the aforementioned allegations of abuse should have been reported timely.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(1)(2)(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>37116</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice to meet each resident's physical, mental, and psychosocial needs for one of 15 residents reviewed (Resident 18).</p> <p>Findings Include:</p> <p>Review of Resident 18's clinical record revealed diagnoses that included congestive heart failure (CHF - weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues) and localized edema (swelling caused by excess fluid accumulation in the body tissues).</p> <p>Review of Resident 18's June and July 2024 TARs (Treatment Administration Records - forms used to document physician orders as well as when and how treatments are administered to a resident) revealed an order for daily weights; call provider if weight gain of more than three pounds in a day, or more than five pounds in a week. This order was effective June 19, 2024. Further review of Resident 18's TARs revealed that no weight, or refusal to be weighed, was recorded on June 23 and 30, 2024, or on July 14 and 16, 2024. Additionally, weights recorded on July 3 and 10, 2024, indicated a weight gain of greater than three pounds from the prior day (6.5 pounds on July 3, 2024; and 4.2 pounds on July 10, 2024), but review of available clinical documentation failed to reveal that the practitioner was notified of the weight gain on either date.</p> <p>During an interview with the Director of Nursing on July 25, 2024, at 1:55 PM, she revealed that she did not have any additional information regarding the missed weights or practitioner notification of weight gain.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>33305</p> <p>Based on clinical record review, policy review, and staff and resident interviews, it was determined that the facility failed to ensure each resident received treatment in accordance with professional standards of practice for one of one resident reviewed (Resident 32) receiving dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidney can no longer perform these functions naturally).</p> <p>Findings Include:</p> <p>A review of the facility policy, titled Hemodialysis Resident Care Standard, last reviewed July 19, 2024, stated that the facility will assure safe medical management of residents who receive dialysis in a dialysis clinic, outside of the facility.</p> <p>Review of Resident 32's clinical record revealed diagnoses that included end stage renal disease (kidneys can no longer filter waste and excess fluids) and atrial fibrillation (irregular and rapid heartbeat).</p> <p>During an interview on July 22, 2024, at 10:00 AM, with Resident 32 it was revealed that that the Resident receives dialysis treatment three times a week at an outside facility.</p> <p>Review of Resident 32's current physician orders revealed orders for check bruit and thrill at AV fistula (surgically created connection between an artery and a vein that provided access for hemodialysis) site every day and evening shift. Further review of Resident 32's orders revealed there were no physician orders for dialysis treatment, name of facility for dialysis treatment, frequency of dialysis, or contact number for dialysis.</p> <p>During an interview on July 25, 2024, at 11:00 AM, with the Director of Nursing (DON), the DON confirmed that Resident 32 receives dialysis treatment three days a week and a physician order should have been written that includes receiving dialysis, name of facility for dialysis treatment, frequency, facility and contact information.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(d) Resident Care Policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(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>37116</p> <p>Based on clinical record review, policy review, and staff interviews, it was determined that the facility failed to ensure that the drug regimen of each resident was reviewed at least monthly by a licensed pharmacist, that irregularities were reported to the appropriate parties, and that these reports were acted upon in a timely manner for four of five residents reviewed for unnecessary medications (Residents 2, 13, 17, and 29).</p> <p>Findings include:</p> <p>Review of facility policy, titled Drug Regimen Review, revised February 2023, revealed, Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review (approximately 30 days). Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to a recommendation directed to him/her within a reasonable time frame, the Director of Nursing, designee, and/or the consultant pharmacist may contact the Medical Director.</p> <p>Review of Resident 2's clinical record revealed diagnoses that included dementia with behavioral disturbance (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life) and delusional disorders (disorder in which a person holds fixed false beliefs and is unable to tell what is real from what is imagined).</p> <p>Review of Resident 2's Medication Regimen Review form dated November 29, 2023, revealed the following recommendation: Please evaluate the clinical appropriateness and alternative therapy for extended usage of Macrobid [antibiotic]. Further review of the form, as well as review of available clinical documentation, failed to reveal that the practitioner provided a timely response to this recommendation.</p> <p>Review of Resident 2's Medication Regimen Review form dated January 24, 2024, revealed the following note: I cannot find November's recommendation in the chart. Please evaluate the clinical appropriateness and alternative therapy for extended usage of Macrobid. Further review of the form revealed the practitioner did not respond to the recommendation until March 22, 2024, almost two months following the recommendation date.</p> <p>Review of Resident 2's Medication Regimen Review form dated June 17, 2024, revealed the following recommendation: Please evaluate the clinical appropriateness and alternative therapy for extended usage of Macrobid. Further review of the form, as well as review of available clinical documentation, failed to reveal that the practitioner reviewed or responded to this recommendation after it was again made.</p> <p>Review of Resident 13's clinical record revealed diagnoses that included vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain that causes problems with reasoning, planning, judgment, and memory) and delusional disorders.</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 13's Medication Regimen Review form dated November 29, 2023, revealed the following recommendation: Please consider D/C [discontinuing] PRN [as-needed] Ondansetron [used to prevent nausea or vomiting]. Resident has not used medication for >60 days. Discontinuing this order will reduce the overall pill burden for the resident. Further review of the form, as well as review of available clinical documentation, failed to reveal that the practitioner provided a timely response to this recommendation.</p> <p>Review of Resident 13's Medication Regimen Review form dated March 21, 2024, revealed the following recommendation: Hydroxyzine [used to treat itching] started on 2/23/24. Did we consider starting at 12.5 mg? Please evaluate the clinical appropriateness and alternatives to Hydroxyzine. Further review of the form, as well as review of available clinical documentation, failed to reveal that the practitioner reviewed or responded to this recommendation.</p> <p>Review of Resident 13's Medication Regimen Review form dated June 17, 2024, revealed the following recommendation: The resident has an ACB score of 6 [Anticholinergic Burden Calculator - used to rate risk of adverse events for patients over 65 based on medications taken] . Your patient scored >3 and is therefore at a higher risk of confusion, falls and death .Please consider alternatives to reduce the overall risk for the resident. Further review of the form, as well as review of available clinical documentation, failed to reveal that the practitioner reviewed or responded to this recommendation.</p> <p>Review of Resident 17's clinical record revealed diagnoses that included dementia (decline in thinking and problem-solving skills) severe with psychotic disturbance and hallucinations (condition causing loss of contact with reality) and mixed anxiety disorders (serious mental health condition causing symptoms of depression and anxiety).</p> <p>Review of pharmacy medication regimen review documents failed to revealed Resident 17's medication had been reviewed in December 2023.</p> <p>Further review of the pharmacy medication regimen review documents revealed a review dated January 24, 2024, with a recommendation for the physician that stated a December 2023 recommendation could not be located in the chart and to evaluate and correct the supporting diagnosis for quetiapine. The physician response was dated March 22, 2024.</p> <p>During a staff interview July 25, 2024, at 12:00 PM, with the Director of Nursing (DON) it was revealed that Resident 17's pharmacy medication regimen review for December 2023 could not be located and that she could not verify that it had been completed.</p> <p>Review of Resident 29's clinical record revealed diagnoses that included congestive heart failure (CHF - weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues) and paroxysmal atrial fibrillation (irregular heart rhythm that can cause symptoms such as fatigue, lightheadedness, and stroke).</p> <p>Review of Resident 29's Medication Regimen Review form dated March 21, 2024, revealed the following recommendation: Please consider changing Colace [stool softener] dosing from 100mg BID [twice daily], to 200mg daily, to reduce the overall pill burden. Further review of the form, as well as review of available clinical documentation, failed to reveal that the practitioner provided a timely response to this recommendation.</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>During an interview with the DON on July 25, 2024, at 1:55 PM, she revealed the expectation that pharmacy recommendations should have been reviewed and responded to in a timely manner.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing 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 - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>33305</p> <p>Based on observation, staff interviews, policy review, and clinical record review, it was determined that the facility failed to document completely and accurately on the clinical records for one of 15 residents reviewed (Resident 86).</p> <p>Findings include:</p> <p>A review of the facility policy, titled Accountability of Medications and Controlled Substances, last reviewed July 17, 2024, informed staff to document the administration of all medications that are administered to residents.</p> <p>Review of the clinical record for Resident 86 on July 23, 2023, revealed diagnoses that included cellulitis of the lower left limb (a common and potentially serious bacterial skin infection) and hypertension (high/elevated blood pressure).</p> <p>Observation of Resident 86 on July 22, 2024, at 9:30 AM, revealed an empty bag of Cefazolin (antibiotic) at the bedside that was administered at 8:00 AM on July 22, 2024, per physician orders.</p> <p>A review of the Resident 86's Admission MDS (Minimum Data Set-periodic assessment of resident needs) dated July 16, 2024, revealed the Resident had a BIMS (brief interview of mental status) score of 15 out of a possible score of 15, indicating that he is cognitively intact.</p> <p>A review of the clinical record revealed that Resident 86 has a physician order for Cefazolin 2 grams intravenously to be administered every 8 hours for cellulitis.</p> <p>A review of Resident 86's medication administration record revealed the nurse never initialed the doses of Cefazolin on July 16, 2024, at 7:00 PM, or on July 19, 2024, at 4:00 AM. A review of the ordered times also revealed the 7:00 PM dose should have been transcribed at 8:00 PM based on the every 8 hours administration time ordered.</p> <p>The Director of Nursing (DON) was able to contact the pharmacy to confirm that three doses are delivered daily, and also confirmed there are no extra doses on the unit that weren't administered, and that the Resident hasn't refused any doses.</p> <p>During an interview with the DON on July 25, 2024, at approximately 11:00 AM, and on July 26, 2024, at approximately 1:15 PM, via telephone correspondence, the DON confirmed that documentation should be complete and transcription of times should be accurate on resident clinical records.</p> <p>28 Pa. Code 211.12(d)(1)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49123</p> <p>Based on facility policy review, observations, and staff interview, it was determined that the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of three residents reviewed for transmission based precautions (Resident 14) and one of one residents reviewed for pressure ulcers (Resident 14).</p> <p>Findings include:</p> <p>Review of facility policy, titled Corporate Infection Control Policy Manual, with a review date of July 17, 2024, read, in part, Purpose: SpiriTrust Lutheran facilities will maintain an infection prevention and control program designed to provide safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections .D. Types of Precautions to be used if isolation required: 1. Hand Hygiene: c. If caring for a resident with a C. Difficile infection, do not use alcohol based hand-rub. d. Hands are to be washed: . (2) Before putting on gloves or other PPE such as gowns, masks, goggles, etc . (5) After removal of dirty gloves and before putting on clean gloves during treatments or wound dressings. (6) After removing gloves when finished caring for a resident or their environment. Clostridium Difficile (C. Difficile) 7. Once an active C. Difficile infection has been diagnosed , the following precautions should be followed: a. Standard and Modified Contact Precautions .c. Proper Hand Hygiene following guidelines d. Alcohol-based hand rubs, gels, or foams are not to be used .e. Sign: placed on room door .f. When caring for the resident with C. difficile infection, wash your hands prior to caring for the resident. Wear gloves .wear a gown during care or exposure to contaminated surfaces. After care, wash your hands. G. Enhanced Barrier Precautions (EBP) b. EBP may be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: i. Wounds .regardless of MDRO colonization status.</p> <p>Review of Resident 14's clinical record revealed diagnoses that included infectious gastroenteritis and colitis (contagious inflammation affecting the stomach and intestines), enterocolitis (inflammation of the digestive tract) due to clostridium difficile (c. diff. - highly contagious bacterial infection of the colon), and chronic peripheral venous insufficiency (improper functioning of the vein valves in the leg, causing swelling and skin changes).</p> <p>Review of Resident 14's current physician's orders revealed Resident 14 was receiving oral vancomycin for infectious gastroenteritis and colitis. Further review of Resident 14's physician's orders also revealed Resident 14 had wound care orders for dressing changes to the right ankle, left first and second toe, and sacrum.</p> <p>Observations of Resident 14's room made on July 22, 2024, at 12:30 PM, and July 23, 2024, at 9:49 AM, failed to reveal signage that indicated contact precautions and EBP were in place, and no personal protection equipment (PPE) was present for use.</p> <p>Review of Resident 14's comprehensive plan of care revealed a focus area for potential for isolation due to c. diff. with an intervention for I am on contact precautions.</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 - Few</p>	<p>Observation of Resident 14's wound care on July 25, 2024, at 9:24 AM, revealed Employee 7 (Licensed Practical Nurse) failed to preform hand washing prior to donning a gown and gloves. During the wound treatment and dressing change, it was observed that Employee 7 failed to preform hand washing after removing the soiled dressing and donning clean gloves. It was also observed that Employee 7 used alcohol-based hand rub after doffing her gown and gloves and exiting Resident 14's room.</p> <p>During a staff interview on July 25, 2024, at 1:42 PM, with the Nursing Home Administrator, the Director of Nursing (DON), and Employee 1, the DON revealed signage for contact precaution and EBP were now in place and a PPE caddy had been placed by Resident 14's door. She stated that it was the facility's expectation that signage would have been in place and PPE be available. The DON also stated that it was the facility's expectation that proper hand washing be performed when performing wound care and caring for residents on contact precautions for c. diff.</p> <p>28. Pa Code 211.12 (d)(1)(5) Nursing Services</p>		