STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396150	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Hanover	3370 High Pointe Boulevard Bethlehem, PA 18017

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)
F 0607 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45125 Based on facility policy review, personnel file review, and staff interview, it was determined that the facility failed to verify professional license/registration prior to the start of employment for two of five newly hired employees. (E3 and E4) Findings include: A review of facility policy entitled, Abuse, dated April 23, 2024, revealed that the facility was to conduct screening for all potential hires. This included license/registration verification. Employee 3 (E3) had been working in the facility as a Registered Nurse since May 24, 2024, and an inquiry to the state licensure board was not completed until July 2, 2024. Employee 4 (E4) had been working in the facility as a nurse aide since May 23, 2024, and an inquiry to the state nurse aide registry had not been completed. In an interview on July 3, 2024, at 9:00 a.m., the Regional [NAME] President of Operations confirmed the license/registry verification for E3 and E4 was not done per facility policy. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.19(3) Personnel policies and procedures.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Hanover		STREET ADDRESS, CITY, STATE, ZIP CODE 3370 High Pointe Boulevard Bethlehem, PA 18017	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48578 Based on review of the Resident Assessment Instrument (RAI) User's Manual, clinical record review, and staff interview, it was determined that the facility failed to complete a Minimum Data Set (MDS) assessment in a timely manner for one of three closed records sampled. (Resident 29) Findings include: Review of the Long-Term Care Facility RAI User's Manual dated October 2023, which provided instructions and guidelines for completing required MDS assessments (federally mandated assessment tool that evaluates resident's functional capabilities and helps nursing home staff identify health problems), revealed that a Discharge assessment is warranted when a resident is admitted to a hospital or other care setting. The Discharge assessment was to be completed and transmitted to the Centers for Medicare and Medicaid Services' Quality Improvement and Evaluation System Assessment Submission and Processing System within 14 days after the Assessment Reference Date (ARD), the day the resident leaves the facility. Clinical record review revealed that Resident 29 was admitted to the facility on [DATE], and remained there until being hospitalized on [DATE]. A Discharge MDS was not completed until July 3, 2024. In an interview on July 3, 2024, at 9:50 a.m., the Regional [NAME] President of Operations confirmed that the MDS assessment had not been completed within the required time frame. 28 Pa. Code 211.5(f) Medical records.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48578 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that physician's orders were implemented for two of 14 sampled residents. (Residents 4, 25) Findings include: Clinical record review revealed that Resident 4 was admitted on [DATE], and had diagnoses that included chronic kidney disease and heart failure. On June 18, 2024, a physician ordered that staff obtain a daily weight for the resident. A review of Resident 4's weights revealed that there was no documented evidence to support a weight was obtained on June 21, 2024. Clinical record review revealed that Resident 25 was admitted on [DATE], and had diagnoses that included end stage renal disease and heart failure. On June 21, 2024, a physician ordered that staff obtain a daily weight for the resident. A review of Resident 25's weights revealed that there was no documented evidence to support a weight was obtained on June 23 and 30, 2024. In an interview on July 3, 2024, at 1:39 p.m., the Regional [NAME] President of Operations confirmed there was no documentation to support that weights were obtained by staff or refused by the residents on the previously mentioned dates. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43883 Based on the facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide ongoing assessment and monitoring for one of one sampled residents receiving hemodialysis. (Resident 101) Findings include: A review of a facility policy entitled, Dialysis Assessment, last reviewed April 23, 2024, revealed that all patients receiving hemodialysis would have their access site (where the blood is accessed for dialysis) assessed every shift. The assessment was to include appearance, signs of infection, drainage, bleeding, and bruit and thrill (sight and sound of blood flow at the site). The assessment was to be documented in the treatment administration record (TAR) by the nurse that conducted the assessment. Clinical record review revealed that Resident 101 was readmitted to the facility on [DATE], and had diagnoses that included end stage renal disease and congestive heart failure. The resident received hemodialysis three times per week. Review of the clinical record, including the TAR for June and July 2024, revealed no evidence that staff assessed the residents access site for appearance, signs of infection, bleeding, or bruit and thrill every shift, per facility policy, since June 27, 2024. In an interview on July 3, 2024, at 2:27 p.m., the Regional [NAME] President of Operations confirmed that there was no evidence that staff assessed the access site. 28 Pa. Code 211.12(1)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43883 Based on facility policy review, observation, and staff interview, it was determined that the facility failed to store food under sanitary conditions in the kitchen. Findings include: A review of a facility policy entitled, Food Storage, last reviewed April 23, 2024, revealed that a thermometer would be present in the dry storage room and the temperature would be monitored on a regular basis. Scoops were not to be stored in food containers. Observation of the kitchen on July 2, 2024, at 9:15 a.m., revealed the following: There was a container of baking chocolate powder that had been removed from the original package; it was not dated. In the walk-in refrigerator, there was a bin of raw chicken stored over a bin of raw shrimp. The shrimp and chicken had been pulled from the freezer to be thawed and were not dated with a pull date. There was a bin of raw pork and a bin of raw turkey that were pulled from the freezer to be thawed and were not dated with a pull date. In an interview, the Director of Dietary confirmed that the items should have been dated. A scoop was in the bulk bin of all-purpose flour; it was in direct contact with the flour. In the dry storage room, there were funnels in a container of salt and a container of pepper; they were in direct contact with the salt and pepper. There was a Styrofoam bowl in a second container of salt; it was in direct contact with the salt. There was no thermometer in the dry storage room. 28 Pa. Code 201.18(e)(1) Management.