

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395387	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/17/2025
NAME OF PROVIDER OR SUPPLIER: FULTON COUNTY MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 214 PEACH ORCHARD ROAD MCCONNELLSBURG, PA 17233		
STATE LICENSE NUMBER: 061902				
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F 0000	INITIAL COMMENT	F 0000		
F 0623 SS=D	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and a Civil Rights Compliance survey completed on April 17, 2025, it was determined that Fulton County Medical Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0623		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0623 SS=D	Continued from page 1 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c) (2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	1. Facility provided transfer and discharge notification report to the State Ombudsman office for the month of March on 4/19/2025. 2. Facility created a formal notification letter on 4/20/2025. Letter that will be updated, specific to each transfer and discharge and be provided to the resident/resident representative starting 4/21/2025. 3. On the spot education began on 4/21/25 for the Interdisciplinary Team and Registered Nurses which reviews Notice requirements 483.15(c)(3)-(6)(8) and new process of notification letter and reporting to ombudsmen. Education will be completed by 5/21/25. 4. Administrator or designee will complete monthly audits of written notification to resident/resident representative and ombudsman reporting. Audits will be completed over 3 consecutive months and findings will be reported at the Quality Assurance and Performance	Completion Date: 06/16/2025 Status: APPROVED Date: 05/08/2025

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F 0623 SS=D	Continued from page 2 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i) (A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623	Improvement meeting.	

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F 0623 SS=D	Continued from page 3 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623		

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F 0623 SS=D	Continued from page 4 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that a written notice regarding emergency transfer to the hospital was provided to the Office of the State Long-Term Care Ombudsman, and failed to ensure that a written notice was provided to the resident and the resident's responsible party regarding the reason for transfer to the hospital for two of 25 residents reviewed (Residents 8, 23). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated March 25, 2025, indicated that the resident was cognitively intact, was understood, could understand others, and required assistance from staff for care needs. A review of the medical record revealed that Resident 8 had his sister listed as the person to be notified in an emergency.	F 0623		

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F 0623 SS=D	<p>Continued from page 5</p> <p>A nursing note, dated September 23, 2024, at 3:45 p.m., revealed that Resident 8 reported he was not himself, was shaking, and was confused. He had developed a skin rash to creases in skin folds, behind his knees, under his arms, and groin. The rash spread to his arms, legs, trunk, and back. He was then sent to the emergency room for evaluation and treatment.</p> <p>Nursing notes, dated January 7, 2025, at 5:52 a.m. and 8:13 a.m., revealed that nursing staff reported that there was blood in the toilet and that Resident 8 appeared to have blood at both his rectum and urethra. After another episode of hematuria (blood in urine) and rectal bleeding the resident reported he did not feel well. He was then sent to the emergency room for evaluation and treatment.</p> <p>There was no documented evidence that a written notice of Resident 8's transfer to the hospital was provided to the State Long-Term Care Ombudsman and that a written notice was provided to the resident and the resident's responsible party</p>	F 0623		

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F 0623 SS=D	<p>Continued from page 6</p> <p>regarding the reason for transfer to the hospital on September 23, 2024, or January 7, 2025.</p> <p>An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 23, dated January 30, 2025, indicated that the resident was cognitively intact, was understood, could understand others, required assistance from staff for care needs, and had diagnoses that included sepsis (a medical emergency in response to an infection).</p> <p>A nursing note, dated March 9, 2025, at 6:45 a.m., revealed that Resident 23 was found to be shaking and experiencing tremors. The resident's blood pressure was abnormal at 142/46, and labwork indicated an elevated white blood cell (cells that fight infection) count. She was then sent to the emergency room for evaluation and treatment.</p> <p>There was no documented evidence that a written notice of Resident 23's transfer to the hospital was provided to the State Long-Term Care Ombudsman</p>	F 0623		

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F 0623 SS=D	Continued from page 7 and that a written notice was provided to the resident and the resident's responsible party regarding the reason for transfer to the hospital on March 9, 2025, Interview with the Director of Nursing on April 15, 2025, at 12:25 p.m. confirmed that there was no documented evidence that a written notice of Resident 8's and 23's transfer to the hospital was provided to the State Long-Term Care Ombudsman and that a written notice was provided to the resident and the resident's responsible party regarding the reason for transfer to the hospital. 28 Pa. Code 201.14(a) Responsibility of Licensee.	F 0623		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 8 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	1. On April 15, 2025 resident 37 care plan was updated to reflect discharge of hemodialysis catheter. No other residents were identified as having this issue. 2. Facility updated change in condition checklist to include discharged orders. Updates to care plan will be verified at morning Interdisciplinary team meeting as change in condition checklist is completed. 3. Facility will complete on the spot education with registered nurses, licensed practical nurses and the interdisciplinary team regarding requirements for timing and revisions of care plan based on §483.21(b)(2)(i)-(iii) and need to update and reflect current care needs. Education will be completed by 5/29/2025 4. Director of Nursing or designee will perform weekly audits that care plan updates have been made in relation to discharge orders. Audits	Completion Date: 06/16/2025 Status: APPROVED Date: 05/08/2025

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F 0657 SS=D	Continued from page 9	F 0657	will be performed weekly for 1 month then monthly for 2 consecutive months. 5. Results of audits will be reported at the Quality Assurance and Performance Improvement meeting.	

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F 0657 SS=D	Continued from page 10 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to revise/update the care plan for one of 25 residents reviewed (Resident 37). Findings include: The facility's policy regarding care plans, dated March 6, 2025, indicated that nurses and interdisciplinary team members were responsible for updating the resident's care plan to reflect changes in the resident's status. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 37, dated September 7, 2024, indicated that the resident was cognitively intact, usually understood and understands, required assistance from staff for his daily care needs, and had diagnoses that included end-stage renal disease. A care plan, dated August 7, 2023, revealed that Resident 37 had a hemodialysis catheter (a type of	F 0657		

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F 0657 SS=D	Continued from page 11 catheter used for vascular access during hemodialysis treatment that is typically inserted into a large vein, such as the jugular or femoral vein, to facilitate the removal and return of blood during hemodialysis sessions) in place. Nursing notes for Resident 37, dated November 6, 2023, indicated that on that day, he had a left upper arm fistula (connection between an artery and a vein to facilitate dialysis) placed at the hospital. Nursing notes, dated May 8, 2024, indicated that on May 7, 2024, the resident had his hemodialysis catheter removed. Interview with the resident on April 15, 2024, at 2:02 p.m. indicated that his hemodialysis catheter was removed and now he has a fistula in his left arm. Interview with the Director of Nursing on April 15, 2025, at 3:25 p.m. confirmed that Resident 37's care plan should have been updated to reflect the fact that the resident's hemodialysis catheter was removed in May 2024 and was now using a fistula	F 0657		

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F 0657 SS=D	Continued from page 12 for dialysis treatment. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0657		
F 0760 SS=E		F 0760		

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F 0760 SS=E	Continued from page 13 483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 0760	<ol style="list-style-type: none"> 1. Facility did not identify any additional residents with dose administration errors. 2. On the spot education initiated on 4/18/2025 for Registered nurses and Licensed practical nurses that reviewed the format of insulin administration orders and the need to read entire order because administration doses can vary at different administration times. 3. Further investigation identified root cause of error as nurse clinical judgement to administer the AC (before meals) dosage because insulin was being administered with evening snack. All errors made by the same licensed practical nurse. 4. Individual education completed on proper usage of AC (before meals) and HS (at bedtime) terminology with employee who made the administration dose error on 4/28/2025. 5. Facility initiated additional on the 	Completion Date: 06/16/2025 Status: APPROVED Date: 05/12/2025

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F 0760 SS=E	Continued from page 14	F 0760	<p>spot education on 5/6/2025 to all registered nurses and licensed practical nurses reviewing the definition of HS and AC and proper use of terminology. Education will be completed by 5/27/2025.</p> <p>6. Director of Nursing will complete weekly dose administration audits on insulin administration given by employee who made the administration error. Audits will be completed weekly for 4 consecutive weeks then monthly for 2 consecutive months.</p> <p>7. Director of Nursing will complete random insulin dose administration audits monthly for 3 consecutive months.</p> <p>8. Results of audits will be reported at the Quality Assurance and Performance Improvement meeting.</p>	

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F 0760 SS=E	Continued from page 15 Based on a review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to ensure that it was free from significant medication errors for one of 25 residents reviewed (Resident 8). Findings include: A facility policy regarding administering medication, dated August March 6, 2025, revealed that staff were to administer medications that were ordered by the physician; to ensure the right resident received the right medication at the right time. Medication given to a resident shall be prescribed by the physician. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated March 25, 2025, indicated that the resident was cognitively intact, required assistance from staff for care needs, had diagnoses that included Type I diabetes (unable to	F 0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395387	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/17/2025
NAME OF PROVIDER OR SUPPLIER: FULTON COUNTY MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 214 PEACH ORCHARD ROAD MCCONNELLSBURG, PA 17233		
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F 0760 SS=E	Continued from page 16 produce insulin needed to regulate blood sugar), and was administered insulin (medication to lower blood sugar). Physician's orders for Resident 8, dated January 10, 2025, included an order for the resident to receive Insulin Admelog (Lispro- a rapid-acting insulin) based on a sliding scale (the amount of insulin is based on the result of a fingerstick blood sugar test) before meals and bedtime. The sliding scale for before meals included giving 3 units of insulin for a blood sugar of 151-200 milligrams per deciliter (mg/dL); 6 units for a blood sugar of 201-250 mg/dL; 9 units for a blood sugar of 251-300 mg/dL; 12 units for a blood sugar of 301-350 mg/dL; and 15 units for a blood sugar of 351-400 mg/dL. The sliding scale for bedtime included giving 0 units of insulin for a blood sugar of 151-200 mg/dL; 2 units for a blood sugar of 201-250 mg/dL; 3 units for a blood sugar of 251-300 mg/dL; 4 units for a blood sugar of 301-350 mg/dL; and 5 units for a blood sugar of 351-400 mg/dL. Special instruction that were included indicated that the dosages of insulin	F 0760		

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F 0760 SS=E	Continued from page 17 for "before meals" and "bedtime" were different and to read the entire scale before administering. Review of the Medication Administration Record (MAR) for Resident 8, dated March and April 2025, revealed that on March 18, 2025, at 7:59 p.m. the resident had a blood sugar of 258 mg/dl and was administered 9 units when 3 units of Admelog was ordered; on March 19, 2025, at 8:24 p.m. the resident had a blood sugar of 268 mg/dl and was administered 9 units when 3 units of Admelog was ordered; on March 20, 2025, at 7:41 p.m. the resident had a blood sugar of 173 mg/dl and was administered 3 units of Admelog when the insulin should have been held as ordered; on March 31, 2025, at 7:56 p.m. the resident had a blood sugar of 202 mg/dl and was administered 6 units when 2 units of Admelog was ordered; on April 3, 2025, at 7:56 p.m. the resident had a blood sugar of 160 mg/dl and was administered 3 units when the insulin should have been held as ordered; on April 7, 2025, at 7:42 p.m. the resident had a blood sugar of 161 mg/dl and was administered 3 units when the	F 0760		

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F 0760 SS=E	Continued from page 18 insulin should have been held as ordered; and on April 15, 2025, at 8:14 p.m. the resident had a blood sugar of 204 mg/dl and was administered 6 units when 2 units of Admelog was ordered. Interview with the Director of Nursing on April 16, 2025, at 9:25 a.m. confirmed that Resident 8's bedtime insulin was not administered as physician ordered for the dates listed above. 28 Pa Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0760		
F 0761 SS=E		F 0761		

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F 0761 SS=E	Continued from page 19 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	1. The facility ensured there are no additional medical supplies in circulation on both Shimer Trail and Overly Meadows that are expired. 2. The facility will update the process for monitoring medical supplies. Night shift licensed practical nurses will be responsible to monitor medical supply storage and ensure supplies are removed from circulation prior to their expiration date. 3. On the spot education of new process will be completed by all registered nurses and licensed practical nurses by 06/16/2025. 4. Semi-monthly audits will be completed by Director of Nursing or designee to ensure new process is being followed and that no expired medical supplies are in circulation. 5. Results of audits will be reported at the Quality Assurance and Performance Improvement meeting.	Completion Date: 06/16/2025 Status: APPROVED Date: 05/08/2025

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F 0761 SS=E	Continued from page 20 Based on observations and staff interviews, it was determined that the facility failed to discard expired medical supplies in two of two medication rooms reviewed (Overly Meadows and Shimer Trails). Findings include: Observations in the Overly Meadows medication room on April 16, 2025, at 11:22 a.m. revealed that there were six 24 gauge angiocatheters (small teflon tubing inserted into the vein to administer fluids or medication) that expired November 30, 2024; one 18 gauge needle expired on January 31, 2021; and one 25 vial box of 20 cc's each normal saline solution that expired on November 1, 2023. Interview with Licensed Practical Nurse 1 on April 16, 2025, at 11:26 a.m. confirmed that the above angiocatheters, needles and syringe should not have been in circulation in the medication room if they were expired.	F 0761		

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F 0761 SS=E	<p>Continued from page 21</p> <p>Observations in the Shimer Trails medication room on April 16, 2025, at 12:20 p.m. revealed that there were nine 24 gauge IV catheters that expired April 30, 2023; two 20 gauge IV catheters that expired August 31, 2023; twenty- seven 22 gauge IV catheters, 26 that expired January 31, 2025, and one that expired December 31, 2024; four 18 gauge needles that expired August 31, 2024; and one 10 cc syringe that expired September 30, 2024.</p> <p>Interview with Licensed Practical Nurse 2 on April 16, 2025, at 12:25 p.m. confirmed that the above angiocatheters, needles and syringe should not have been in circulation in the medication room if they were expired.</p> <p>Interview with the Nursing Home Administrator on April 16, 2025, at at 12:46 p.m. confirmed that the intravenous catheters, needles and syringe should not have been in circulation in the medication rooms if they were expired, and they were.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy Services.</p>	F 0761		

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F 0761 SS=E	Continued from page 22	F 0761		
F 0849 SS=D		F 0849		

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F 0849 SS=D	Continued from page 23 483.70(n)(1)-(4) Hospice Services §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 0849	1. Facility ensured that Benefit of election from and required documents were filed into resident 27 and resident 36 clinical chart on 4/18/2025. Facility has no additional Hospice residents at this time. 2. Facility social worker has been identified as coordinator to ensure communication the plan is implemented and that appropriate documents are available in the physical chart for the interdisciplinary team with all future hospice admissions as of 4/25/25. 3. Facility and Hospice provider will implement a communication plan that ensures physical documents are available in the physical chart for interdisciplinary team review by 5/23/2025. 4. Facility will complete on the spot education regarding communication plan to their interdisciplinary team as well as Hospice Director of Business Development by 5/30/2025	Completion Date: 06/16/2025 Status: APPROVED Date: 05/08/2025

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F 0849 SS=D	Continued from page 24 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and	F 0849	5. Administrator or designee will complete monthly audits of new hospice charts to ensure communication plan is in place and that required documentation is available to the interdisciplinary team in the chart. Audits will be conducted for 3 consecutive months and results will be reported at Quality Assurance and Performance Improvement Meeting.	

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F 0849 SS=D	Continued from page 25 drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and	F 0849		

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F 0849 SS=D	Continued from page 26 capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any)	F 0849		

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F 0849 SS=D	Continued from page 27 orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by:	F 0849		

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F 0849 SS=D	Continued from page 28 Based on review of hospice contracts, facility policies, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the designated interdisciplinary team member obtained the required information from the contracted hospice provider for two of 25 residents reviewed (Residents 27, 36) who received hospice services. Findings include: An agreement between the facility and a hospice provider (provider of end-of-life services), dated March 9, 2018, revealed that it was the responsibility of the hospice to provide information to the skilled nursing facility to include plan of care, Benefit of Election form (a form used to formally enroll a patient in hospice care), advance directives, certification and recertification of terminal illness (a form signed by the resident's hospice physician and specific to each patient), names and contact info of hospice personnel, instructions for access of hospice	F 0849		

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F 0849 SS=D	Continued from page 29 24 hour on-call system, hospice medication information, hospice and attending orders. The facility's policy regarding hospice care (specialized care that provides physical comfort and emotional, social and spiritual support for people nearing the end of life), dated March 6, 2025, revealed that residents electing to receive hospice services will be referred to the hospice agency of choice, and care will be coordinated with the nursing home through the interdisciplinary care planning process. Nursing will communicate with hospice in coordinating the resident's overall care and incorporate hospice care into the resident's care plan. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 27, dated February 6, 2025, revealed that the resident was usually understood, could usually understand others, had diagnoses that included heart failure (occurs when the heart can not pump enough blood to meet	F 0849		

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F 0849 SS=D	Continued from page 30 the body's needs), and adult failure to thrive (a syndrome characterized by a decline in a person's overall health, function, and well-being, often accompanied by symptoms like weight loss, decreased appetite, and cognitive impairment), and received hospice care. A care plan, dated January 31, 2025, revealed that the resident had an anticipated decline due to the progression of the disease process, with a less than six months life expectancy. A nursing note for Resident 27, dated January 31, 2025, revealed that the resident was admitted to the facility this afternoon and that the resident was receiving hospice care. A hospice provider care plan for Resident 27, for the hospice certification period of February 23, 2025, through April 23, 2025, revealed that the hospice nurse would visit the resident two times per week for six weeks, then one time a week for one week and would make four as needed visits for any changes in condition.	F 0849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395387	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/17/2025	
NAME OF PROVIDER OR SUPPLIER: FULTON COUNTY MEDICAL CENTER STATE LICENSE NUMBER: 061902		STREET ADDRESS, CITY, STATE, ZIP CODE: 214 PEACH ORCHARD ROAD MCCONNELLSBURG, PA 17233		
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F 0849 SS=D	Continued from page 31 As of April 17, 2025, there was no documented evidence that Resident 27's clinical record and/or the hospice provider's clinical record contained the Hospice Benefit of Election form and communication from the contracted hospice provider after March 14, 2025. An admission MDS assessment for Resident 36, dated March 18, 2025, revealed that the resident was sometimes understood, could sometimes understand others, had a diagnoses that included cerebral vascular accident (CVA - commonly known as a stroke) with hemiplegia (paralysis on one side of the body), aphasia (a language disorder that results from damage to the brain's language centers, affecting the ability to speak, understand language, and read or write), and adult failure to thrive, and received hospice care. A care plan, dated March 12, 2025, revealed that the resident has an anticipated decline due to the progression of the disease process, with a less than six months life expectancy.	F 0849		

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F 0849 SS=D	Continued from page 32 A nursing note for Resident 36, dated March 12, 2025, revealed that the resident was admitted to the facility, and that the resident has been receiving hospice care for the past two months. As of April 17, 2025, there was no documented evidence that Resident 36's clinical record and the hospice provider's clinical record contained the Hospice Benefit of Election form. Interview with the Nursing Home Administrator on April 17, 2025, at 11:00 a.m. confirmed that the Hospice Benefit of Election form and Hospice nurse visit notes for Resident 27 and the Hospice Benefit of Election form for Resident 36 had to be faxed over from the contracted hospice provider and that there was no documented evidence that as of April 17, 2025, that the above information was in Resident 27's and Resident 36's clinical records and/or the hospice provider's clinical records. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.	F 0849		

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F 0849 SS=D	Continued from page 33	F 0849		
F 0880 SS=D		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395387	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/17/2025	
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F 0880 SS=D	Continued from page 34 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1. Facility provided immediate education to employee who failed to ensure proper infection control practices during wound care. 2. Facility initiated on the spot education to all registered nurses and licensed practical nurses on 4/18/2025 regarding general hand hygiene practices and specific to wound care procedures. Education will be completed by 5/18/2025. 3. Hand hygiene competency, specific to wound care procedures, will be added annual education and competency requirements starting 6/1/2025. 4. Random wound care observation audits will be completed by Director of Nursing or designee once a week for 4 weeks, then monthly for 2 consecutive months. 5. Results of audits will be reported at the Quality Assurance and Performance Improvement meeting.	Completion Date: 06/16/2025 Status: APPROVED Date: 05/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395387	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/17/2025	
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F 0880 SS=D	Continued from page 35 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 36	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395387	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/17/2025	
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F 0880 SS=D	Continued from page 37 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper infection control practices were followed during wound care for one of 25 residents reviewed (Resident 23). Findings include: The facility's policy regarding hand hygiene, dated March 6, 2025, indicated that hand hygiene is an important infection control measure to prevent illness in skilled nursing homes, and that hands should be sanitized or washed before and after the use of gloves. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 23, dated January 30, 2024, indicated that the resident was cognitively intact, was understood, could understand others, required assistance from staff for care needs, and	F 0880		

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F 0880 SS=D	Continued from page 38 had diagnoses that included left arm hematoma (blood clot) and sepsis (a medical emergency in response to an infection). Physician's orders for Resident 23, dated April 11, 2025, included an order to cleanse the left arm with normal saline (salt water) solution, lightly pack 1/4-inch iodoform (sterile gauze infused with antiseptic) into left forearm surgical site, cover with gauze, abdominal pad and kerlix then secure with tape. Observations on April 16, 2025, at 1:30 p.m. revealed that Licensed Practical Nurse 1 donned a gown and gloves and with scissors she removed Resident 23's left forearm dressing, cleansed the area with normal saline infused gauze, removed her gloves and without performing hand hygiene she donned new ones. Using a Q-tip she packed the wound with a 1/4-inch iodoform packing strip; covered the area with gauze, an abdominal pad, and kerlix and secured it with tape; gathered the garbage; and without removing her gloves and performing hand hygiene, Licensed Practical Nurse 1 repositioned three of the resident's pillows, then	F 0880		

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F 0880 SS=D	Continued from page 39 removed her gloves and washed her hands. Interview with Licensed Practical Nurse 1 on April 16, 2025, at 1:45 p.m. confirmed that while performing wound care on Resident 23, she did not perform hand hygiene after removing her gloves and donning new gloves, and did not remove her gloves and hand sanitize prior to repositioning the resident's pillows. Interview with the Director of Nursing on April 16, 2025, at 3:18 p.m. confirmed that Licensed Practical Nurse 1 should have washed her hands or sanitized them after removing her gloves and before donning new gloves, and should have removed her gloves and performed hand hygiene prior to repositioning Resident 23's pillows. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0880		
F 0908 SS=D		F 0908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395387	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/17/2025
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F 0908 SS=D	Continued from page 40 483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 0908	<p>1. On 4/17/2025 Facility Director of Environmental Services contacted manufacturer to determine delivery date of part to repair the automated dispenser. The anticipated delivery date given was May 1.</p> <p>2. On the spot education completed 4/18/2025 with laundry personnel. Additional education to general housekeepers was completed on 5/1/2025. Education included manufacturer's instructions on manual application of detergent if automated system is not functional.</p> <p>3. Automatic dispenser part was repaired and is now functional as of 4/30/2025.</p> <p>4. Facility completed on the spot education to all staff reviewing that work orders need to be entered when equipment needs repaired. If staff do not have access to enter work orders, the Registered Nurse should be notified. Education will be completed by 6/16/2025.</p>	Completion Date: 06/16/2025 Status: APPROVED Date: 05/08/2025

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F 0908 SS=D	Continued from page 41	F 0908	5. Administrator or designee will complete random audits weekly for 4 weeks and then monthly for 2 consecutive months to ensure work orders are put in for equipment that needs repair.	

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F 0908 SS=D	Continued from page 42 Based on review of manufacturer's direction for use, as well as observations and staff interviews, it was determined that the facility failed to ensure essential equipment was in safe operating condition in the facility's laundry area. Findings include: A facility policy regarding chemical dispensing, dated August March 6, 2025, indicated that the automatic dispensing system was to ensure safe dispensing of chemicals for the laundry department. The automatic liquid dispensing system would dispense chemicals for the recommended amounts of detergent per the chemical manufacturer. Observations in the laundry department on April 18, 2025, at 12:50 p.m. revealed that the laundry area had two washing machines. There was a five-gallon bucket on the floor and a smaller bucket on the counter with blue liquid in it. Interview with Environmental Service Staff (ESS) 3 at the time of	F 0908		

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F 0908 SS=D	Continued from page 43 the observation revealed that the second washing machine's automatic feeder was not working and was not adding the detergent to the washing machine. She had to open the five-gallon bucket on the floor that had plastic tubing to the automatic feeding system, transfer some of the detergent to another bucket using a clear handled cup to put approximately 1/4 cup in the washer. This issue has been a concern for about three months, and she reported it to her supervisor. ESS 3 was the primary staff responsible for operating the facilities personal laundry. Interview with the Nursing Home Administrator on April 17, 2025, at 1:05 p.m. revealed that the Environmental Service Director was aware that the automatic detergent feeder was not working. The Environmental Service Director had contacted the company for replacement parts but was unsure when, and had no other contact with the manufacturer. Interview with the Nursing Home Administrator on	F 0908		

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F 0908 SS=D	Continued from page 44 April 17, 2025, at 1:35 p.m. revealed that she was unaware that the automatic feeding system was not working, there were no work orders for the repairs, and confirmed that the washing machine should be in functional order. 28 Pa. Code 201.18(b)(3) Administrator's Responsibility.	F 0908			



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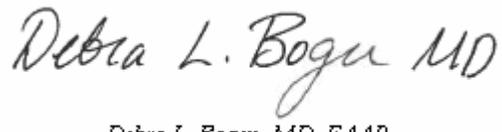
FULTON COUNTY MEDICAL CENTER

STATE LICENSE NUMBER: 061902

SURVEY EXIT DATE: 04/17/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

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