STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395426	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PREMIER AT PERRY VILLAGE FOR NURSING AND REHABILITATION, LLC STATE LICENSE NUMBER: **161002**	**213 EAST MAIN STREET** **NEW BLOOMFIELD, PA 17068**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey and Civil Rights Compliance Survey completed on December 5, 2024, it was determined that Premier at Perry Village For Nursing and Rehabilitation, LLC 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 0000		
F 0580 SS=D		F 0580		

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 0580 SS=D	Continued from page 1 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this	F 0580	1. The physician was notified of the incident for resident 44. 2. An initial audit of residents who have had incidents with potential for negative outcomes was completed to ensure the physician was notified. 3. Nursing staff were educated on need to notify physicians timely of incidents with potential for negative outcomes. 4. 5 audits of incidents for MD notification will be audited weekly x 4, then monthly x 2 to ensure compliance by DON or designee. Results of these audits will be presented to the QAA committee for review. 5. The facility will be in substantial compliance by 1/7/25.	Completion Date: **01/07/2025** Status: **APPROVED** Date: **12/13/2024**

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F 0580 SS=D	Continued from page 2 section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 0580		

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F 0580 SS=D	Continued from page 3 Based on facility policy review, clinical record reviews, facility document reviews, and staff interviews, it was determined that the facility failed to timely notify a resident's physician of an incident that had the potential to result in a negative outcome for one of 21 residents reviewed (Resident 44). Findings Include: Review of facility policy, titled "Change in a Resident's Condition or Status", with a last review date of October 24, 2024, revealed, in part, "facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status;" and "The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): accident or incident involving the resident." Review of Resident 44's clinical record revealed diagnoses that included metabolic encephalopathy (a change in how your brain works due to an	F 0580		

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F 0580 SS=D	Continued from page 4 underlying condition that can cause confusion, memory loss and loss of consciousness), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), depression, and low back pain. Review of Resident 44's clinical record revealed a nursing progress note written by Employee 2 (Registered Nurse) dated November 7, 2024, at 11:30 AM, that indicated a staff member quickly came out of the Resident's room stating, "He has a bag of pills, and he just took a handful of them telling me that they were candy". Amount unknown. This nurse went directly into the room and saw the Resident hurriedly putting the bag in his bedside drawer. When asked what he was eating, he nonchalantly turned his head towards this nurse and stated "Candy". The note further indicated that staff were able to retrieve the bag and that the "medication was all of one kind and was determined to be 500 mg Tylenol."	F 0580		

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F 0580 SS=D	Continued from page 5 Review of Resident 44's clinical record revealed a nursing progress note written by Employee 3 (Registered Nurse) dated November 8, 2024, at 4:53 AM, that indicated the "incident occurred at 23:30 [11:30 PM] and not 11:30 [AM]as originally documented. This nurse placed the bag of pills in the DON [Director of Nursing] office." Review of Resident 44's clinical record revealed a nursing progress note written by Employee 3 dated November 8, 2024, at 6:25 AM, that indicated it was a late entry and that the nurse had checked on Resident 44 throughout the night to monitor for any signs and symptoms of "Tylenol toxicity d/t [due to] unknown amount of Tylenol taken by resident from his baggy that was found of OTC [over the counter] Tylenol from the CNA [certified nurse aide] at the beginning of nightshift." The note further indicated that Resident 44 had not exhibited any signs or symptoms and was acting his normal self. Review of Resident 44's clinical record revealed a nursing progress note written by Employee 4	F 0580		

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F 0580 SS=D	Continued from page 6 (Registered Nurse) dated November 8, 2024, at 7:00 AM, that indicated "Dayshift RN [Registered Nurse] updated to possible ingestion of OTC ES [extra strength] Tylenol and in to assess the resident. Resident placed on alert charting to monitor for any s/s [signs and symptoms] of discoloration/yellow hue to skin, any c/o [complaints of] N(ausea) & V(omiting) or not feeling well, any c/o abdominal pain, or new onset of confusion. RN called MD and awaiting response for possible need of blood work to determine what acetaminophen level is or other orders at this time." Review of Resident 44's clinical record revealed a nursing progress note written by Employee 5 (Registered Nurse) dated November 8, 2024, at 7:34 AM, that indicated "MD made aware of possible OTC medication ingestion and that staff are uncertain how much medication was taken. He was also made aware that resident does not have any visible symptoms of toxicity at this time. See new orders to send resident to ED for Toxicity workup." The note further indicated that Employee 5 had a	F 0580		

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F 0580 SS=D	Continued from page 7 discussion with Resident 44 about the over-the-counter medications in his room, the physician's order to send him to the hospital for an evaluation, and that he agreed to go after discussion. Review of Resident 44's facility provided incident report dated November 7, 2024, at 11:30 PM, completed by Employee 4 indicated that it was prepared based on staff interviews, revealed that a nurse aide had reported to the 3-11 RN Supervisor that Resident 44 had a bag of pills on him and that the nurse aide had witnessed him take a handful of them. It further indicated that Resident 44 told the nurse aide that they were "candy" and that when the RN arrived in Resident 44's room, the RN witnessed Resident 44 attempting to place the plastic bag of pills in the bedside drawer. The incident report further indicated that the DON was notified on November 8, 2024, at 4:53 AM, and that Resident 44's physician was notified on November 8, 2024, at 7:42 AM. During a staff interview with the Nursing Home	F 0580		

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F 0580 SS=D	Continued from page 8 Administrator (NHA) and DON on December 5, 2024, at 9:45 AM, the DON indicated that staff had reached out to her about the incident and that staff had monitored him throughout the night and he had no negative outcomes nor any signs or symptoms of toxicity noted. The DON further indicated that the dayshift RN came in and did her due diligence and notified the MD of the occurrence and that was when orders were received to send out to be evaluated. The DON indicated that Resident 44 was sent to the hospital and all testing was negative and he was sent back to the facility with no new orders. The NHA indicated that they have "no proof that he in fact took the Tylenol since he called it candy." She said that the daughter did admit that she brought him in Tylenol as well as Tic Tacs. NHA indicated that she met with Resident 44's family because they were upset that the over-the-counter medication was taken away from him. The NHA said she explained the safety/process of self-administering medications when in a facility. During a staff interview with Employee 6	F 0580		

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F 0580 SS=D	Continued from page 9 (Registered Nurse) on December 5, 2024, at 11:41 AM, Employee 6 indicated that they were working the morning of November 8, 2024, and that they had received report on Resident 44 from Employee 3 regarding the medication incident. Employee 6 indicated that they could not recall if Employee 3 said they had notified Resident 44's physician of the possible ingestion of an unknown amount of Tylenol. Employee 6 said that they felt inclined to let Resident 44's physician know about what had happened. Employee 6 said that it was discussed with the physician about having labs drawn at the facility, but the physician was concerned regarding the amount of time it would take to get the results back and, therefore, the physician ordered Resident 44 to be sent to the emergency department for an evaluation. Employee 6 indicated that Employee 5 (Registered Nurse) was also present that morning. During a staff interview with Employee 5 on December 5, 2024, at 11:50 AM, Employee 5 indicated that Employee 3 confirmed during shift report that they had not notified Resident 44's	F 0580		

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F 0580 SS=D	Continued from page 10 physician of the possible medication ingestion of an unknown amount of Tylenol and that Employee 3 gave no rationale as to why they did not call Resident 44's physician at the time of the incident. Employee 5 indicated that as soon as they were made aware of the incident in shift report they along with Employee 6 immediately notified Resident 44's physician. During a staff interview with the NHA on December 5, 2024, at 11:59 AM, the NHA indicated that, according to their facility policy, they have 24 hours to notify the physician and that Resident 44's physician was notified within that timeframe. The NHA indicated that Resident 44 was monitored and no significant change in his condition. The NHA indicated that she felt that there was no urgent situation to report as they could not confirm that Resident 44 actually took the medication. The concern was discussed that Employees 5 and 6 (Registered Nurses) indicated that both felt the physician should have been notified at the time of the occurrence and that Employees 2 and 3 (Registered	F 0580		

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F 0580 SS=D	Continued from page 11 Nurses) had not reported it to Resident 44's physician. In addition, the concern was shared that when Resident 44's physician was finally made aware of the incident approximately 8 hours after it had occurred, he ordered Resident 44 to be sent to the emergency department for evaluation. 201.14(a) Responsibility of licensee 201.18(b)(1) Management 211.12(d)(1)(2)(3)(5) Nursing service	F 0580		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 12 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	1. Residents 8 and 60 had modifications of their MDS completed. 2. An initial audit of MDS completed in the past 30 days was completed to ensure accuracy of Section O0110 C1 and P0200 A. 3. Education was completed with MDS staff on ensuring accuracy of these sections of the MDS. 4. 5 audits of Section O0110 C1 and 5 audits of Section P0200 A will be completed weekly x 4, then monthly x 2 by DON or designee. Results of these audits will be shared with the QAA committee for review. 5. The facility will be in substantial compliance by 1/7/25.	Completion Date: **01/07/2025** Status: **APPROVED** Date: **12/13/2024**

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F 0641 SS=D	Continued from page 13 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for two of 21 residents reviewed (Residents 8 and 60). Findings Include: Review of Resident 8's clinical record revealed diagnoses that included hypertension (high blood pressure) and anxiety (a feeling of worry, nervousness, or unease). Review of Resident 8's clinical record revealed a physician's order for Oxygen via nasal cannula to maintain saturation above 91 as needed for shortness of breath, with an active date of November 6, 2024. Review of Resident 8's clinical record revealed Resident 8 was administered oxygen via nasal cannula on November 6, 7, 8, and 9, 2024.	F 0641		

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F 0641 SS=D	Continued from page 14 Review of Resident 8's MDS (Minimum Data Set is part of the federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated November 11, 2024, revealed that Section O0110. C1. Oxygen therapy was marked No. During an interview with the Nursing Home Administrator (NHA) on December 4, 2024, at 6:08 PM, revealed Resident 8's MDS dated November 11, 2024, has been modified to reflect oxygen use. Review of Resident 60's clinical record revealed diagnoses that included major depressive disorder (a serious mental illness that can affect how a person feels, thinks, and acts) and dementia (a chronic condition that causes a decline in cognitive abilities, such as thinking, memory, and reasoning, that interferes with daily life). Review of Resident 60's clinical record revealed a physician's order for Bed alarm, with an active date	F 0641		

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F 0641 SS=D	Continued from page 15 of November 14, 2024. Review of Resident 60's MDS dated November 16, 2023, revealed that Section P0200. A. Bed Alarm was marked No. During an interview with the NHA on December 4, 2024, at 12:31 PM, revealed that the MDS dated November 16, 2024, should have reflected Resident 60's bed alarm use, and a modification will be made. 28 Pa. Code 211.5(f) Medical records 28 Pa Code 211.12(d)(3)(5) Nursing services	F 0641		
F 0656 SS=D		F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395426	A. BLDG: 00 B. WING:	12/05/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
PREMIER AT PERRY VILLAGE FOR NURSING AND REHABILITATION, LLC STATE LICENSE NUMBER: **161002**	**213 EAST MAIN STREET NEW BLOOMFIELD, PA 17068**

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F 0656 SS=D	Continued from page 16 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	1. Residents 10, 60, and 75 had their care plans corrected to reflect smoking and dementia diagnosis. 2. An initial audit of residents who smoke and residents with dementia diagnosis was completed to ensure that their care plans reflect these items. 3. Education was completed with nursing staff, therapy staff, and IDT on ensuring that care plans are developed for residents who smoke and residents that have dementia diagnosis. 4. 5 audits of residents who smoke and 5 residents with dementia diagnosis will be conducted weekly x 4, then monthly x 2 by DON or designee. Results of these audits will be presented to the QAA committee for review. 5. The facility will be in substantial compliance by 1/7/25.	Completion Date: **01/07/2025** Status: **APPROVED** Date: **12/13/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0656 SS=D	Continued from page 17 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 18 Based on clinical record review and resident and staff interviews, it was determined that the facility failed to develop a comprehensive person-centered care plan to address the resident's medical, physical, mental, and psychosocial needs for three of 21 records reviewed (Residents 10, 60, and 75). Findings include: Review of Resident 10's clinical record revealed diagnoses that included major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and hypertension (elevated blood pressure). During an interview with Resident 10 on December 2, 2024, at 12:38 PM, she stated that she is a smoker with staff supervision. Review of Resident 10's clinical record revealed a smoking contract was signed by Resident 10 on August 27, 2024, and the most recent smoking	F 0656		

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F 0656 SS=D	Continued from page 19 evaluation was completed on November 12, 2024, which revealed Resident 10 could smoke with supervision. Review of Resident 10's current care plan failed to reveal a smoking care plan. On December 4, 2024, at 10:58 AM, the Nursing Home Administrator (NHA) stated that a smoking care plan has been added for Resident 10 and provided the smoking care plan, with an initiation date of December 4, 2024. During a follow-up interview with the NHA on December 4, 2024, at 2:00 PM, she confirmed that a smoking care plan was not in place prior to December 4, 2024. Review of Resident 60's clinical record revealed diagnoses that included major depressive disorder (a serious mental illness that can affect how a person feels, thinks, and acts) and dementia (a chronic condition that causes a decline in cognitive abilities,	F 0656		

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F 0656 SS=D	Continued from page 20 such as thinking, memory, and reasoning, that interferes with daily life). Review of Resident 60's clinical record revealed they were admitted to the facility on November 9, 2024, with a diagnosis of Alzheimer's disease as well as Dementia. Review of Resident 60's current care plan failed to reveal a dementia care plan. On December 4, 2024, at 12:31 PM, the NHA revealed a dementia care plan was added to Resident 60's care plan, with a focus area to include the Resident has impaired cognitive function/dementia or impaired thought process, with a revision date of December 4, 2024. During an additional interview with the NHA on December 4, 2024, at 2:08 PM, revealed she would have expected Resident 60's care plan to include a dementia focus area upon admission.	F 0656		

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F 0656 SS=D	Continued from page 21 Review of Resident 75's clinical record revealed diagnoses that included urinary retention (a condition in which you are unable to empty all the urine from your bladder) and cancer. During an interview with Resident 75 on December 2, 2024, at 10:08 AM, Resident 75 indicated that the Resident is a smoker and that residents who smoke must do so outside and that staff must supervise them. Review of Resident 75's clinical record revealed that the Resident had a smoking evaluation completed on June 21, 2024 (which indicated Resident 75 was a smoker); September 15, 2024 (which indicated Resident 75 was a non-smoker); and November 7, 2024 (which indicated that Resident 75 was a smoker). Review of Resident 75's clinical record revealed that the Resident had signed the facility's "Smoking Contract" on August 27, 2024.	F 0656		

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F 0656 SS=D	Continued from page 22 Review of Resident 75's care plan failed to reveal that the Resident was a smoker. Email communication received from the NHA on December 4, 2024, at 6:55 PM, indicated that Resident 75's care plan was updated to reflect their desire to smoke. During a staff interview with the NHA and Director of Nursing on December 5, 2024, at 9:33 AM, the NHA confirmed that Resident 75's care plan should have included their desire to smoke prior to yesterday. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services	F 0656		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 23 483.21(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. Residents 1, 11, and 60 had their care plans revised. 2. An initial audit of residents who had antianxiety medications discontinued in the past 30 days was completed to ensure accuracy, as well as, and initial audit of residents who have had diet changes in the past 30 days has been conducted to ensure accuracy. 3. Education was completed with nursing staff, and the IDT on ensuring that care plans are updated timely with any revision. 4. 5 audits of residents with discontinued antianxiety medications and 5 audits of residents with diet changes will be conducted weekly x 4, then monthly x 2 by DON or designee. Results of these audits will be presented to the QAA committee. 5. The facility will be in substantial compliance by 1/7/25.	Completion Date: **01/07/2025** Status: **APPROVED** Date: **12/13/2024**

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F 0657 SS=D	Continued from page 24 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for three of 21 residents reviewed (Residents 1, 11, and 60). Findings Include: Review of Resident 1's clinical record revealed diagnoses that included epilepsy (a brain condition causing recurring seizures) and multiple sclerosis (a chronic autoimmune disease that affects the central nervous system). Review of Resident 1's care plan on December 2, 2024, revealed a care plan with a focus area of, Resident has an alteration in neurological function, with an intervention of IM (intramuscular) Ativan (benzodiazepine medication) as needed for seizure activity, with a date initiated of July 3, 2024. Review of Resident 1's physician orders on December 2, 2024, failed to reveal an order for Ativan for Resident 1.	F 0657		

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F 0657 SS=D	Continued from page 25 Interview with the Nursing Home Administrator (NHA) on December 4, 2024, at 5:47 PM, revealed that Resident 1's Ativan was discounted in May 2024 and the care plan should have been updated at that time. Review of Resident 11's clinical record revealed diagnoses that included chronic kidney disease (a disease characterized by progressive damage and loss of function of the kidneys) and diabetes (a disease that affects how the body utilizes blood glucose). Review of Resident 11's physician orders on December 2, 2024, revealed an order for, CCHO (consistent, controlled carbohydrate), liberal renal diet with dysphagia advanced texture, and thin consistency. Review of Resident 11's care plan on December 2, 2024, revealed a care plan with a focus area of, Diet: CCHO, dysphagia advanced, thin liquids, no	F 0657		

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F 0657 SS=D	Continued from page 26 salt packet, with a revision date of June 27, 2023. Interview with the NHA on December 4, 2024, at 5:47 PM, revealed that Resident 11's care plan should have been updated so that it would match Resident 11's current physician's orders. Review of Resident 60's clinical record revealed diagnoses that included major depressive disorder (a serious mental illness that can affect how a person feels, thinks, and acts) and dementia (a chronic condition that causes a decline in cognitive abilities, such as thinking, memory, and reasoning, that interferes with daily life). Review of Resident 60's current physician orders revealed a diet order for regular diet, regular texture, thin consistency, with an active date of November 10, 2024. Review of Resident 60's care plan revealed a focus area which included the Resident may experience weight changes due to ordered therapeutic altered	F 0657		

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F 0657 SS=D	Continued from page 27 diet related to diabetes, with an initiation date of November 8, 2024. During an interview with the NHA on December 5, 2024, revealed Resident 60's care plan is incorrect as the Resident is not on a therapeutic diet, and that it should have been updated to reflect their current diet. 28 Pa. Code 211.12(d)(5) Nursing services	F 0657		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 28 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1. Resident 44 had orders revised to reflect BiPAP use. 2. An initial audit of residents who use BiPAPs was conducted to ensure accuracy with physician orders. 3. Education was completed with licensed nursing staff on ensuring that orders for BiPAPs are completed. 4. 2 new admissions will be audited for BiPAP orders weekly x 4, then monthly x 2 by DON or designee. Results of this audit will be presented to the QAA committee for review. 5. The facility will be in substantial compliance by 1/7/25.	Completion Date: **01/07/2025** Status: **APPROVED** Date: **12/13/2024**

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F 0695 SS=D	Continued from page 29 Based on review of facility policy, clinical record review, observations, and staff interview, it was determined that the facility failed to provide respiratory care/oxygen services consistent with professional standards of practice for one of four residents reviewed (Resident 44). Findings include: Review of facility policy, titled "Continuous Positive Airway Pressure", with a last review date of October 24, 2024, indicated that Continuous Positive Airway Pressure or CPAP is "a medical device which uses compressed air to keep the air passage open so breathing continues normally" and that "CPAP must be ordered by a physician." Review of Resident 44's clinical record revealed diagnoses that included obstructive sleep apnea (intermittent airflow blockage during sleep) and asthma (condition in which a person's airways become inflamed, narrow, and swell, and produce extra mucus which makes it difficult to breathe).	F 0695		

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F 0695 SS=D	Continued from page 30 Observations of Resident 44 on December 2, 2024, at 10:48 AM, and December 4, 2024, at 11:14 AM, revealed the presence of a CPAP (continuous positive airway pressure which is a type of ventilator that uses mild air pressure to keep breathing airways open while one sleeps) or BiPAP (bi-level positive airway pressure which is a type of ventilator used to treat sleep apnea) machine sitting at the Resident's bedside. Review of Resident's 44's current physician orders failed to reveal an order for CPAP or BiPAP. Review of Resident 44's physician order history revealed that there was no order for CPAP or BiPAP since their admission to the facility on October 29, 2024. Review of Resident 44's nursing progress notes revealed that the Resident was documented as using CPAP on October 30 and 31, 2024; November 6, 7, 10, 11, and 12, 2024; and December 1 and 2,	F 0695		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0695 SS=D	Continued from page 31 2024. In addition, Resident 44 was documented as using a BiPAP on November 5, 2024. Review of Resident 44's care plan revealed that the Resident was care planned for "CPAP at HS [bedtime] per order", dated October 30, 2024. Email communication received from the Nursing Home Administrator (NHA) on December 4, 2024, at 6:33 PM, indicated that Resident 44 "uses BiPAP not CPAP." During a staff interview with the NHA on December 5, 2024, at 11:33 AM, the NHA confirmed that Resident 44 did not have a physician order for their BiPAP prior to yesterday and that an order should have been obtained when Resident 44's BiPAP machine was brought into the facility. 28 Pa code 211.12(d)(1)(2)(5) Nursing services	F 0695		
F 0810 SS=D		F 0810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395426	A. BLDG: __00_____ B. WING: _____	12/05/2024

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F 0810 SS=D	Continued from page 32 483.60(g) Assistive Devices - Eating Equipment/Utensils §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by:	F 0810	1. Resident 53 had no adverse effect from not receiving kennedy cup with noon meal. 2. An initial audit of resident who use kennedy cups was completed to ensure that it was received as ordered. 3. Education was completed with dietary and nursing staff on ensuring that kennedy cups are provided as ordered. 4. 5 audits of residents who require kennedy cups will be conducted weekly x 4, then monthly x 2 by NHA or designee. Results of this audit will be presented to the QAA committee for review. 5. The facility will be in substantial compliance by 1/7/25.	Completion Date: **01/07/2025** Status: **APPROVED** Date: **12/13/2024**

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F 0810 SS=D	Continued from page 33 Based on observations, policy review, clinical record review, and staff interview, it was determined that the facility failed to provide adaptive feeding devices for one of 21 residents reviewed (Resident 53). Findings include: Review of facility policy, titled "Assistance with Meals", last reviewed October 2024, read, in part, adaptive devices (special eating equipment and utensils) will be provided for residents who need them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups. Review of Resident 53's clinical record revealed diagnoses that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine) and anxiety (a feeling of worry, nervousness, or unease).	F 0810		

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F 0810 SS=D	Continued from page 34 Review of Resident 53's current active physician orders included: Equipment: lip plate, and Kennedy cup with meals, with an active date of September 10, 2024. Review of Resident 53's care plan included a focus area for nutrition risk, initiated date April 28, 2022, and revised May 26, 2022; with focus areas that included Equipment: lip plate and Kennedy cup with meals, initiated date November 3, 2023. Observation on December 2, 2024, at 12:18 PM, revealed Resident 53 was delivered lunch in his room that contained a lipped plate, however, did not include a Kennedy cup. Observation on December 3, 2024, at 12:31 PM, revealed Resident 53 was delivered lunch in his room that contained a lipped plate, however, did not include a Kennedy cup. Observation on December 4, 2024, at 12:33 PM,	F 0810		

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F 0810 SS=D	Continued from page 35 revealed Resident 53 was delivered lunch in his room that contained a lipped plate, however, did not include a Kennedy cup. Interview with the Nursing Home Administrator on December 4, 2024, at 6:08 PM, revealed she would have expected Resident 53 to have been served a Kennedy cup with his meals. 28 Pa code 211.6(a) - Dietary Services	F 0810		
F 0812 SS=D		F 0812		

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F 0812 SS=D	Continued from page 36 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. Employee 1 was provided education on not touching nonfood items with the same gloves as touching food items. 2. Observational audits of meal service (tray line) for 3 meals per day x 3 days to ensure appropriate sanitary service. 3. Education was provided to the dietary staff on proper procedure on performing tray line. 4. 2 weekly observations of tray line will be conducted weekly x 4, then monthly x 2 by NHA or designee. Results of this audit will be presented to the QAA committee for review. 5. The facility will be in substantial compliance by 1/7/25.	Completion Date: **01/07/2025** Status: **APPROVED** Date: **12/13/2024**

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F 0812 SS=D	Continued from page 37 Based on observations and staff interview, it was determined that the facility failed to serve food in a sanitary manner during one of one tray line observations in the kitchen. Findings include: Observation of food service tray line on December 4, 2024, at 11:54 AM, revealed that Employee 1 (Cook) was wearing gloves on both hands. Employee 1 was observed to pick up a resident tray ticket from the top of a cart next to the food service line and lay it on a resident tray. Employee 1 was then observed to open a package of hamburger buns by ripping a hole in the bag. Employee 1 was then observed to removing a hamburger bun from the package using their same gloved hands which had touched the tray ticket and the hamburger bun packaging. Employee 1 was then observed reaching into a bin, removing lettuce and tomato, and placing them on a resident plate using their same gloved hands. Observation of Employee 1 revealed that the Employee was continuing to touch tray tickets,	F 0812		

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F 0812 SS=D	Continued from page 38 hamburger buns, lettuce, and tomato with the same gloved hands for three additional resident trays observed. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing on December 4, 2024, at 2:26 PM, the NHA confirmed that she would expect dietary staff not to have direct contact with resident food items after having direct contact with non-food items such as tray tickets and food packaging. 28 Pa. Code 211.6(f) Dietary services 28 Pa. Code 201.18(b)(1) Management	F 0812		
F 0868 SS=D		F 0868		

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F 0868 SS=D	Continued from page 39 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) QAA Committee §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member	F 0868	1. The facility was unable to find quarter 1 signature sheet for QAA meeting. 2. The facility has conducted monthly QAA meetings since April of 2024. Signature sheets were available for review. An audit of these signature sheets was completed to ensure that meetings were conducted monthly. 3. Education was provided to the QAA committee on the importance of conducting QAA meetings as scheduled. 4. QAA meeting will be audited monthly x 2 by NHA or designee. The results of these audits will be presented to the QAA committee for review, 5. The facility will be in substantial compliance by 1/7/25.	Completion Date: **01/07/2025** Status: **APPROVED** Date: **12/13/2024**

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F 0868 SS=D	Continued from page 40 of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:	F 0868		

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F 0868 SS=D	Continued from page 41 Based on facility document review and staff interviews, it was determined that the facility failed to provide evidence that Quality Assurance Committee meetings were held at least quarterly for one of four quarters reviewed (First Quarter of 2024). Findings include: Review of all available documentation submitted by the facility revealed no evidence that the facility conducted a Quality Assurance (QA) Committee meeting during the first quarter of 2024 (January, February, March). During an interview with the Nursing Home Administrator (NHA) on December 2, 2024, at 9:41 AM, she stated that the first quarter QA meeting was held with the prior administration at the facility and that the prior administration did not provide her with the sign in sheet for the first quarter QA meeting upon their exit from the facility.	F 0868		

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F 0868 SS=D	Continued from page 42 In a follow-up interview with the NHA on December 5, 2024, at 10:09 AM, she again confirmed she was unable to provide evidence that the QA meeting was held during the first quarter of 2024, under the prior administration. 28 Pa code 201.18(b)(3) Management	F 0868		

Certified End Page

PREMIER AT PERRY VILLAGE FOR NURSING AND REHABILITATION, LLC

STATE LICENSE NUMBER: 161002

SURVEY EXIT DATE: 12/05/2024

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
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY