

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395440	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/16/2025
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NAME OF PROVIDER OR SUPPLIER: CAMP HILL SKILLED NURSING AND REHABILITATION CENTER	STATE LICENSE NUMBER: 382102	STREET ADDRESS, CITY, STATE, ZIP CODE: 1700 MARKET STREET CAMP HILL, PA 17011
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F 0000	INITIAL COMMENT	F 0000		
F 0582 SS=D	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey and a complaint survey completed on January 16, 2025, it was determined that Camp Hill Skilled Nursing and Rehabilitation Center was not in compliance with the 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 0582		

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 0582 SS=D	Continued from page 1 483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation	F 0582	1. SNF-ABN notice provided to Residents 28 and 108 by Social Services Director 2. DON or Designee will complete a comprehensive review of all current residents to ensure provision of a SNF-ABN notice when applicable. 3. To ensure continuity of care, NHA or Designee will provide re-education to the Social Services Directors on FTag 582 Medicaid/Medicare Coverage Liability Notices. 4. Director of Nursing / Designee will conduct three resident SNF-ABN audits per week for 4 weeks, followed by three resident SNF-ABN audits per month for two months. 5. Results will be reported at Quarterly QAPI Meetings to determine the need for further audits.	Completion Date: 03/03/2025 Status: APPROVED Date: 01/31/2025

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F 0582 SS=D	Continued from page 2 of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 0582		

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F 0582 SS=D	Continued from page 3 Based on review of clinical record review, review of select facility documentation, and staff interview, it was determined that the facility failed to provide the required notices to the resident or their representatives following the end of their Medicare coverage for two of three residents reviewed for beneficiary notices (Residents 28 and 108). Findings include: A Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form completed by the facility revealed that Medicare Part A coverage for Resident 28 started on December 9, 2024, and that her last covered day was January 6, 2025. The form indicated that the facility initiated discontinuation from Medicare Part A coverage and that the Resident's benefit days were not exhausted. Further review of the form indicated that a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF-ABN - a notice given to Medicare beneficiaries to convey that Medicare is not likely to provide coverage for a skilled service)	F 0582		

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F 0582 SS=D	Continued from page 4 was issued telephonically. Review of Resident 28's clinical record revealed that she remained in the facility following the discontinuation of her Medicare A coverage on January 6, 2025. A Skilled Nursing Facility Beneficiary Protection Notification Review Form completed by the facility revealed that Medicare A coverage for Resident 108 started on October 1, 2024, and that her last covered day was October 30, 2024. The form indicated that the facility initiated discontinuation from Medicare Part A coverage and that the Resident's benefit days were not exhausted. Further review of the form indicated that a SNF-ABN notice was not sent at that time. Review of Resident 108's clinical record revealed that she remained at the facility following the discontinuation of her Medicare A coverage on October 30, 2024.	F 0582		

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F 0582 SS=D	Continued from page 5 During an interview with the Nursing Home Administrator on January 16, 2025, at 12:30 PM, she was not able to provide any additional evidence that written SNF-ABN notices were provided to either Resident 28 or 108 as noted above. 28 Pa. Code 201.18(e)(1) Management	F 0582		
F 0584 SS=D		F 0584		

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F 0584 SS=D	Continued from page 6 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1. Resident 105 and 106 were discharged from the facility. 2. A comprehensive review of residents that discharged within the last 30 days will be conducted to ensure an inventory of personal effects is documented for all belongings. A review of all current residents will be completed to ensure that an inventory sheet is completed. 3. The facility will take further steps to validate the problem does not re-occur by re-educating the nursing staff on FTag 584, re-educating on the Patient's Personal Property policy and completion of the Inventory Sheet upon admission and verified upon discharge. 4. Compliance will be monitored by the Director of Nursing/Designee using the Homelike Environment audit to ensure that there is a completed Inventory Sheet of the patient's personal belongings upon admission and that it is verified, signed and copied upon discharge through an audit of all discharges weekly x 3 weeks then five audits monthly x 2 months.	Completion Date: 03/03/2025 Status: APPROVED Date: 02/06/2025

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F 0584 SS=D	Continued from page 7 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	5. Results will be reported to the QAA Committee who will determine the need for further audits.	

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F 0584 SS=D	Continued from page 8 Based on clinical record review and staff interview, it was determined that the facility failed to exercise reasonable care for the protection of the resident's property from loss or theft for two of three discharged residents reviewed (Residents 105 and 106). Findings include: Review of Resident 105's clinical record revealed she was admitted to the facility on November 5, 2024, and discharged from the facility to the hospital on November 12, 2024. Further review of the closed clinical record revealed no documented inventory of personal effects or accounting for Resident 105's personal effects following discharge. Review of Resident 106's clinical record revealed he was admitted to the facility on September 4, 2024, and passed away at the facility on December 25, 2024. Further review of the closed clinical record revealed no documented inventory of personal effects, or accounting for Resident 106's personal	F 0584		

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F 0584 SS=D	Continued from page 9 effects following discharge. During an interview with the Director of Nursing on January 16, 2025, at 12:30 PM, she revealed that she was not able to locate a documented inventory of Resident 105's or 106's personal effects, nor confirm the disposition of these personal effects upon discharge. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2)(e)(1) Management	F 0584		
F 0609 SS=D		F 0609		

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F 0609 SS=D	Continued from page 10 483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0609	1. The facility can not retroactively correct cited deficiency. 2. A comprehensive review of the reports submitted from the last three months will be completed to ensure the PB-22 reporting form was submitted within five days. 3. The facility will take further steps to validate the problem does not reoccur by re-educating the Administrator / Designees on FTag 609 with a focus on timely PB22 submissions. 4. Compliance will be monitored by the Director of Nursing/Designee using the Reporting audit through two audits weekly x 3 audits. 5. Results will be reported to the QAA Committee who will determine the need for further audits.	Completion Date: 03/03/2025 Status: APPROVED Date: 01/31/2025

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F 0609 SS=D	Continued from page 11 Based on facility policy review, review of incident investigation documentation, and staff interview, it was determined that the facility failed to report the results of an abuse investigation within the specified timeframes for one of one abuse incidents reviewed. Findings include: Review of facility policy, "Abuse Prohibition", revised October 24, 2022, revealed, The Administrator or designee will report findings of all completed investigations within five (5) working days to the Department of Health using the state on-line reporting system or state-approved forms." Review of state form, "PB-22 Report Form For Investigation of Alleged Abuse, Neglect, Misappropriation of Property", completed by the facility, revealed that an alleged incident of neglect occurred on September 24, 2024. Further review of the form revealed that the facility became aware of the incident and began an abuse investigation on September 25, 2024. The investigation was	F 0609		

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F 0609 SS=D	Continued from page 12 concluded on September 26, 2024. Review of the form indicated that it was not completed and submitted to the Department of Health until October 7, 2024 (greater than five working days following the conclusion of the investigation). During an interview with the Nursing Home Administrator on January 16, 2025, at 9:15 AM, she revealed that the PB-22 submission was untimely because the Director of Nursing was not at work due to illness. She also revealed the expectation that the Administrator at the time should have submitted the investigation results (PB-22 form) in her absence. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management	F 0609		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 13 483.20(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. MDS correction was completed and submitted for resident 8 to indicate that he did not receive an anticoagulant. MDS correction was completed and submitted for Resident 36 to reflect the most recent date of GDR contraindication. 2. A comprehensive review of current residents will be done to ensure correct coding of anticoagulant use. A comprehensive review of current residents taking an antipsychotic medication will be completed to ensure that the MDS is coded correctly in regards to Gradual Dose Reductions. 3. The facility will take further steps to validate the problem does not reoccur by re-educating the Clinical Reimbursement Coordinators on FTAG 641 accuracy of assessments with focus on anticoagulation therapy and Gradual Dose Reduction coding. 4. Compliance will be monitored by the Director of Nursing/Designee using the MDS Coding Audit through three MDS Assessment audits weekly x 3 weeks to validate	Completion Date: 03/03/2025 Status: APPROVED Date: 02/03/2025

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F 0641 SS=D	Continued from page 14	F 0641	that the MDS is coded accurately in regards to anticoagulant use and Gradual dose reductions. Results will be reported to the QAA committee and the QAA committee will determine the need for further audits.	

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F 0641 SS=D	Continued from page 15 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for two of 24 residents reviewed (Residents 8 and 36). Findings include: Review of Resident 8's clinical record revealed diagnoses that included congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), chronic kidney disease (a condition characterized by a gradual loss of kidney function), and muscle weakness. Review of Resident 8's Annual MDS (Minimum Data Set- assessment tool utilized to identify residents' physical, mental, and psychosocial needs) with ARD (assessment reference date- last day of the assessment period) of December 4, 2024, revealed under Section N. Medications, Resident 8 was marked "yes" to indicate he received an anticoagulant.	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395440	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/16/2025
NAME OF PROVIDER OR SUPPLIER: CAMP HILL SKILLED NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1700 MARKET STREET CAMP HILL, PA 17011		
STATE LICENSE NUMBER: 382102				
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F 0641 SS=D	Continued from page 16 Review of Resident 8's Medicare 5 Day MDS with ARD of December 4, 2024, revealed under Section N, Resident 8 was marked "yes" to indicate he received an anticoagulant. Review of Resident 8's clinical record failed to reveal he was prescribed or received an anticoagulant medication during the ARD. During an email correspondence with the Director of Nursing (DON) on January 15, 2024, at 9:57 AM, she revealed Resident 8's MDS assessments were revised to reflect that he did not receive an anticoagulant during the ARD for those assessments. Follow-up interview with the DON on January 15, 2024, at 11:27 AM, revealed she would expect Resident 8's MDS assessments to be coded accurately. Review of Resident 36's clinical record revealed diagnoses that included bipolar disorder (a lifelong	F 0641		

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F 0641 SS=D	Continued from page 17 mood disorder and mental health condition that causes intense shifts in mood, energy levels, thinking patterns, and behaviors) and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 36's current physician orders revealed that the Resident had an order for an antipsychotic medication, dated February 23, 2021. Review of Resident 36's clinical record revealed a psychiatric visit note dated July 11, 2024, that indicated that a gradual dose reduction of their antipsychotic medication was clinically contraindicated. Review of Resident 36's Annual MDS with ARD of August 8, 2024, revealed in Section N. Medications that the date Resident 36's physician documented that a gradual dose reduction was clinically contraindicated was May 30, 2024.	F 0641		

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F 0641 SS=D	Continued from page 18 Review of Resident 36's clinical record revealed a psychiatric visit note dated November 15, 2024, that indicated that a gradual dose reduction of their antipsychotic medication was clinically contraindicated. Review of Resident 36's Quarterly MDS with the assessment reference date of December 24, 2024, revealed in Section N. Medications, that the date Resident 36's physician documented that a gradual dose reduction was clinically contraindicated was September 20, 2024. During a staff interview with the Nursing Home Administrator and DON on January 16, 2025, at 12:35 PM, the DON confirmed that Resident 36's MDS's were coded in error and modifications were completed. She further indicated that she would expect a resident's MDS assessment to be coded accurately. 28 Pa Code 211.12 (d)(3)(5) Nursing services	F 0641		

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F 0656 SS=D	<p>483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan</p> <p>§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 -</p> <p>(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</p> <p>(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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future 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</p>	F 0656	<p>Resident 29's care plan has been updated to address the use of antianxiety, antidepressant, and anticoagulant medication use. Resident 47 is discharged from the facility.</p> <p>A comprehensive review of current residents who self administer medications, or who take antianxiety, antidepressant, anticoagulant medications will be completed by the Director of Nursing/Designee to ensure that those items are appropriately care planned.</p> <p>The facility will take further steps to validate the problem does not reoccur by re-educating the Unit Managers/RN Supervisors on Ftage 656, Nursing Policy 309 "Medication Self-Administration" and Policy OPS416 "Person- centered care plan. Compliance will be monitored by the Director of Nursing/Designee using the Care Plan Audit. Four audits will be completed weekly x 2weeks and monthly x 2 and results will be reported to the QAA Committee who will determine the need for further audits.</p>	<p>Completion Date: 03/03/2025</p> <p>Status: APPROVED</p> <p>Date: 01/31/2025</p>

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F 0656 SS=D	Continued from page 20 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	<p>Continued from page 21</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop comprehensive care plans for two of 27 resident records reviewed (Residents 29 and 47).</p> <p>Findings Include:</p> <p>Review of Resident 29's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and anxiety disorder (mental health conditions that involve persistent and excessive feelings of fear or worry).</p> <p>Review of Resident 29's current physician orders revealed an order for Buspirone hydrochloride (HCL) tablet 15 milligram (MG) - give one tablet by mouth two times a day for anxiety, with an original active date of July 19, 2024.</p> <p>Review of Resident 29's current physician orders revealed an order for Duloxetine HCL capsule delayed release particles 60 MG -give one capsule by mouth one time a day for depression, with an</p>	F 0656		

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F 0656 SS=D	Continued from page 22 original active date of July 20, 2024. Review of Resident 29's current physician orders revealed an order for Enoxaparin Sodium Injection Solution Prefilled syringe 40 MG/0.4 milliliter - inject 40 MG intramuscularly every 24 hours for blood thinner, with an active date of December 11, 2024. Review of Resident 29's current care plan failed to reveal a plan of care addressing her antianxiety, antidepressant, and anticoagulant medication use. During an interview with the Director of Nursing (DON) on January 16, 2025, at 9:37 AM, revealed she would have expected Resident 29 to have had a baseline care plan for her antianxiety, antidepressant, and anticoagulant medication use. Review of Resident 47's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (a chronic lung disease that makes it difficult to breathe) and heart failure (when	F 0656		

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F 0656 SS=D	Continued from page 23 the heart cannot pump enough blood and oxygen to the body). Review of facility policy, titled "NSG309 Medications: Self-administration", last reviewed and revised on October 15, 2024, revealed, "self-administration and medication self-storage must be care planned." During an interview with Resident 47 on January 13, 2025, at 10:06 AM, she revealed she self-administers her nebulizer medications, and opened her bedside table drawer to show where they are. Review of Resident 47's clinical record revealed a Nursing Progress note written on December 10, 2024, for a self-administration of medication assessment completed on Resident 47 that determined she is fully capable of administering inhalants or inhalers and can keep medications at bedside.	F 0656		

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F 0656 SS=D	Continued from page 24 Review of Resident 47's current care plan failed to reveal a plan of care addressing her self-administering medications. During an interview with the DON on January 16, 2025, at 12:21 PM, revealed she would have expected Resident 47 to have a baseline care plan for her self-administration and storage of medications. 42 CFR 483.21(b) Comprehensive Care Plans 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0656		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 25 483.21(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. Resident 50's care plan has been updated to reflect that Prevalon Boots should be on when in bed. Resident 19's care plan meeting has been rescheduled and she has been invited to it. 2. A comprehensive review of current residents' orders will be completed by the Director of Nursing/Designee to ensure order for Prevalon boots is reflected on the care plan. A comprehensive review of current residents will be reviewed by the Social Services Director to ensure quarterly care plan meetings have been scheduled and that residents were invited to attend. 3. The facility will take the further steps to validate the problem does not reoccur by re-educating the Unit Managers/RN Supervisors and Social Services on FTAG 657 Care plan timing and revision with focus on Care plan meetings and preventative skin care measures. 4. Compliance will be monitored by	Completion Date: 03/03/2025 Status: APPROVED Date: 01/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395440	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/16/2025	
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F 0657 SS=D	Continued from page 26	F 0657	the Director of Nursing/Designee, using the Care Plan Audit through a review of four residents weekly x 2 weeks and monthly x 2 to ensure accuracy of the resident's comprehensive plan of care and resident participation in care plan meetings. Results will be reported to the QAA committee and the QAA committee will determine the need for further audits.	

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F 0657 SS=D	Continued from page 27 Based on facility policy review, observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the residents right to participate in the care planning process for one of 24 residents reviewed (Resident 19), and failed to review and revise the resident plan of care for one of 24 residents reviewed (Resident 50). Findings include: Review of facility policy, titled "OPS416 Person-Centered Care Plan", dated November 28, 2016, with a revision date of October 24, 2022, and a last review date of October 15, 2024, revealed "7. Care plans will be: 7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals; and 9. The Center has the responsibility to assist patients to participate by: 9.3 Facilitating the inclusion of the patient/ resident representative(s) to	F 0657		

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F 0657 SS=D	Continued from page 28 attend." Review of Resident 19's clinical record revealed diagnoses that included chronic pain, hypertension (persistent high blood pressure), and muscle wasting and atrophy (loss of muscle mass). Interview with Resident 19 on January 13, 2024, at 10:03 AM, revealed she does not remember getting invited to her care plan meetings. Review of Resident 19's clinical record revealed a progress note on January 13, 2024, at 1:48 PM, that stated, "Scheduled care plan meeting for January 14, 2024, at 1:30 PM." Further review of Resident 19's clinical record revealed a progress note on January 14, 2024, at 1:38 PM, that stated "Called the family for a scheduled care plan meeting. The family did not answer, left a message." Interview with Resident 19 on January 15, 2024, at	F 0657		

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F 0657 SS=D	Continued from page 29 9:26 AM, revealed she was unaware she had a care plan meeting yesterday. Interview with Employee 2 (Social Services Director) on January 15, 2024, at 10:38 AM, revealed usually, if the family does not attend, nursing will check and see if the Resident would like to attend. She further revealed the surveyor could check with Employee 7 (Registered Nurse) to see if the Resident was invited and declined, and that she was unable to locate documentation to indicate Resident 19 has had a quarterly care plan meeting scheduled since August 14, 2024. Interview with Employee 7 on January 15, 2024, at 10:42 AM, revealed she was not sure as to why Resident 19 did not attend her care plan meeting yesterday. Interview with the Nursing Home Administrator (NHA) on January 16, 2024, at 9:24 AM, revealed she would expect residents are invited to their quarterly care plan meetings.	F 0657		

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F 0657 SS=D	<p>Continued from page 30</p> <p>Review of Resident 50's clinical record revealed diagnoses that included hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting left non-dominant side, muscle weakness, and other abnormalities of gait and mobility.</p> <p>Observations of Resident 50 on January 13, 2025, at 9:59 AM, revealed that the Resident was in bed and noted to have foam boots lying on the chair near the foot of their bed.</p> <p>Review of Resident 50's current physician orders revealed an order for Prevalon Boots (heel protectors that help reduce the risk of bedsores by keeping the heel floated, relieving pressure) on when in bed, off when out of bed, entered by the prescriber dated November 26, 2024.</p> <p>Follow-up observations of Resident 50 on January</p>	F 0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395440	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/16/2025	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0657 SS=D	Continued from page 31 14, 2025, at 9:26 AM and 1:32 PM; and January 15, 2025, at 9:46 AM, revealed the same observations. Review of Resident 50's care plan revealed a care plan focus for being at risk for loss of range of motion related to physical limitations, last revised on August 14, 2024; and at risk for skin breakdown related to limited mobility and shear and friction risks, last revised on March 22, 2024. The care plan failed to reveal any documentation for the intervention of the Prevalon boots. During an interview with the NHA and Director of Nursing (DON) on January 16, 2025, at 9:35 AM, the DON indicated that she noted that the practitioner put the order in for the boots and it was not put in properly and, therefore, did not trigger for staff to implement. When it was discussed that the boots were present in Resident 50's room January 13-16, 2025, the DON indicated that she was unsure how the boots were present in the room if staff did not know Resident 50 was to have them.	F 0657		

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F 0657 SS=D	Continued from page 32 The DON confirmed that she would probably expect staff to have asked about them when they saw them in the room. During a final interview with the NHA and DON on January 16, 2025, at 12:20 PM, the DON indicated that she had no additional information to provide regarding Resident 50's Prevalon boots. She confirmed that Resident 50's care plan should have been revised to include the Prevalon boots and that the Prevalon boots should have been implemented. 28 Pa. Code 211.10(c)(d)(a) Resident care policies 28 Pa. Code 211.12(d)(2)(3)(5) Nursing services	F 0657		
F 0677 SS=E		F 0677		

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F 0677 SS=E	Continued from page 33 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	<ol style="list-style-type: none"> 1. Resident 35 was offered and assisted with shaving facial hair. Resident 101 was offered and assisted with shaving facial hair. 2. A comprehensive review of current residents who are coded as maximal assist or dependent on the MDS will be conducted to ensure that they are offered to be shaved on their shower days and provided feeding assistance timely. 3. The facility will take further steps to validate the problem does not re-occur by re-educating the licensed nurses and nursing assistants on FTag 677 and nursing policy NSG200 Activities of Daily Living. 4. Compliance will be monitored by the Director of Nursing/Designee using the ADL Care audit through a review of three residents weekly x 3 weeks to monitor if shaving was offered and three residents weekly x 3 weeks for timely feeding assistance. Random Audits will then be completed monthly x 2 to monitor for timely feeding and shaving offered with ADLs. Findings will be 	Completion Date: 03/03/2025 Status: APPROVED Date: 02/03/2025

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F 0677 SS=E	Continued from page 34	F 0677	reported to the QAA Committee to determine the need for further audits.	

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F 0677 SS=E	Continued from page 35 Based on facility policy review, observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal hygiene for three of 24 residents reviewed (Residents 20, 35, and 101). Findings include: Review of facility policy, titled "NSG200 Activities of Daily Living (ADLs)" [Activities of daily living or ADLs are routine tasks that each of us must perform every day to care for our bodies and ourselves independently] dated June 1, 1996, with a revision date of May 1, 2023, and a last review date of October 15, 2024, revealed "1. Patients are assessed upon admission, quarterly, and with any significant change to identify their status in all areas of ADL's" and "4.2 A patient who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and	F 0677		

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F 0677 SS=E	Continued from page 36 personal and oral hygiene." Review of Resident 20's clinical record revealed diagnoses that included hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting right dominant side, aphasia (language disorder that affects a person's ability to communicate), and vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults). Observation during lunch meal service on January 13, 2025, at 12:19 PM, revealed Employee 8 (Nurse Aide) placed Resident 20's tray on her tray table in front of her, left it covered and not set-up, and did not return to provide feeding assistance until 12:39 PM. Review of Resident 20's clinical record revealed she required substantial/maximal assistance with eating.	F 0677		

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F 0677 SS=E	<p>Continued from page 37</p> <p>Review of Resident 20's care plan revealed a focus area of "ADL Self-care deficit as evidenced by right sided weakness and generalized weakness related to recent and previous strokes", last revised August 26, 2024, with an intervention for "Assist with daily hygiene, grooming, dressing, oral care and eating as needed", last revised on January 30, 2024.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on January 16, 2025, at 9:25 AM, the surveyor revealed the concern with the process of nursing staff providing a meal tray to a resident 20 minutes prior to being able to provide feeding assistance. The NHA confirmed that staff should not have provided the meal tray to Resident 20 until they were able to provide feeding assistance.</p> <p>Review of Resident 35's clinical record revealed diagnoses that included hemiplegia and hemiparesis following a cerebral infarction affecting right dominant side, aphasia, and vascular dementia (brain damage caused by multiple strokes which</p>	F 0677		

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F 0677 SS=E	Continued from page 38 causes memory loss in older adults). Observation of Resident 35 on January 13, 2025, at 9:41 AM, revealed the presence of dark facial hair on her upper lip and chin. Review of Resident 35's care plan revealed a focus for ADL self-care deficit related to physical limitations, with a revised date of November 7, 2024. Interventions included, but were not limited to, assist with bathing/showering, frequently refuses shower, prefers bed bath, will continue to offer shower, daily hygiene, grooming, dressing, oral care and eating as needed, with a revised date of March 19, 2024; and assist of 2 with ADL's, with a revised date of July 10, 2024. Review of Resident 35's Quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of November 2, 2024, revealed	F 0677		

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F 0677 SS=E	Continued from page 39 in Section GG Functional Abilities, in subsection 0310 Self-Care at Question I Personal Hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene) that she was coded as dependent. During a follow-up observation of Resident 35 on January 14, 2025, at 1:30 PM, revealed the same observation of the presence of moderate dark facial hair on her upper lip and chin. During an immediate interview with Resident 35 when asked if she would like to be shaved, Resident 35 rubbed her chin with her left hand and mouthed the word "yes" while also nodding her head yes. Review of Resident 35's task documentation for bathing/showering for the past 30 days revealed that she had received a bed bath on December 16, 19, 23, 26, and 30, 2024, and January 2, 6, and 13, 2025.	F 0677		

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F 0677 SS=E	Continued from page 40 During a staff interview with the NHA and DON on January 15, 2025, at 11:00 AM, the DON indicated that shaving would only be completed if a resident requested it to be done. Observation of Resident 35 on January 16, 2025, at 9:02 AM, revealed that she had been shaved. Resident 35 was observed to rub her chin with her left hand and smile when asked about being shaved. During a final interview with the NHA and DON on January 16, 2025, at 12:21 PM, the DON confirmed that staff should have offered Resident 35 to be shaved as part of her ADL care since the Resident she was dependent for care. Review of Resident 101's clinical record revealed diagnoses that included muscle wasting and atrophy (loss of muscle mass) and Alzheimer's disease (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning).	F 0677		

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F 0677 SS=E	<p>Continued from page 41</p> <p>Observation of Resident 101 on January 13, 2025, at 12:19 PM, revealed she had three-quarters of an inch facial hair on her chin.</p> <p>Follow-up observations on January 14, 2025, at 9:45 AM, and January 15, 2025, at 9:25 AM, revealed the same observations of three-quarters of an inch facial hair on her chin.</p> <p>Review of Resident 101's task documentation for bathing/showering revealed that she had received a shower on January 13, 2025, at 2:32 PM.</p> <p>Review of Resident 101's care plan revealed a focus area Resident/Patient is at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to Delirium (confusion), behavioral symptoms" last revised December 11, 2024, with an intervention for "ADL: 1 Assist" created on December 11, 2024.</p> <p>During a final interview with the NHA and DON on</p>	F 0677		

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F 0677 SS=E	Continued from page 42 January 16, 2025, at 9:26 AM, the DON revealed that staff offered to shave her on January 15, 2025, and they should have offered it during her shower as part of her ADL care. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services	F 0677		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 43 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	<ol style="list-style-type: none"> 1. Resident 71 has been discharged from the facility. Wound assessment has been completed for resident 88. 2. A comprehensive review of current residents with orders to call MD for blood glucose level outside of the parameters will be completed to ensure that there is documentation that the provider was notified if BS is outside of the parameters within the last 30 days. A comprehensive review of current residents with identified MASD will be conducted to ensure that there are weekly skin evaluations completed for the last 30 days. 3. The facility will take further steps to validate the problem does not re-occur by in-servicing the Licensed Nurses on Ftag 684 with a focus on physician notifications and weekly wound evaluations. 4. Compliance will be monitored by the Director of Nursing/Designee using the Blood Glucose Audit and Wound Audit through an audit of five residents weekly x 3 weeks and monthly x 2 per each individual concern. Findings will be reported to 	Completion Date: 03/03/2025 Status: APPROVED Date: 02/03/2025

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F 0684 SS=D	Continued from page 44	F 0684	the QAA Committee to determine the need for further audits.	

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F 0684 SS=D	Continued from page 45 Based on review of the clinical record and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for two of 24 residents reviewed (Residents 71 and 88). Findings include: Review of Resident 71's clinical record revealed diagnoses that included peripheral vascular disease (a slow and progressive circulation disorder) and hypertension (elevated blood pressure). Review of Resident 71's December 2024 MAR (Medication Administration Record) revealed a physician's order for Blood Glucose before meals - notify MD (Medical Director) if blood sugar less than 80 or blood sugar greater than 250 before meals for Glucose monitoring, with a start date of December 26, 2024.	F 0684		

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F 0684 SS=D	Continued from page 46 Review of Resident 71's December 2024 MAR revealed the following: On December 26, 2024, at 4:00 PM, Resident 71's blood sugar was 286. On December 31, 2024, at 6:00 AM, Resident 71's blood sugar was 316. On December 31, 2024, at 11:00 AM, Resident 71's blood sugar was 252. Review of Resident 71's January 2025 MAR revealed a physician's order for Blood Glucose before meals - notify MD if blood sugar less than 80 or blood sugar greater than 250 before meals for Glucose monitoring, with a start date of December 26, 2024. Review of Resident 71's January 2025 MAR revealed the following: On January 1, 2025, at 6:00 AM, Resident 71's blood sugar was 268. On January 5, 2025, at 11:00 AM, Resident 71's blood sugar was 308. On January 10, 2025, at 6:00 AM, Resident 71's	F 0684		

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F 0684 SS=D	<p>Continued from page 47</p> <p>blood sugar was 266. On January 10, 2025, at 11:00 AM, Resident 71's blood sugar was 283. On January 11, 2025, at 6:00 AM, Resident 71's blood sugar was 255.</p> <p>Review of Resident 71's clinical record failed to reveal the MD was notified of his blood sugar levels being outside of parameters per the physician's order on the dates and times noted above.</p> <p>The facility was unable to provide any evidence of the MD being notified of his blood sugar levels being outside of parameters per the physician's order on the dates and times noted above.</p> <p>During an interview with the Director of Nursing (DON) on January 16, 2025, at 9:31 AM, she revealed she would have expected the MD to have been notified of Resident 71's blood sugar being outside of parameters per the physician's order on the dates and times noted above.</p>	F 0684		

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F 0684 SS=D	Continued from page 48 Review of Resident 88's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (a chronic lung disease that makes it difficult to breathe) and heart failure (when the heart cannot pump enough blood and oxygen to the body). Review of Resident 88's clinical record revealed the Resident had a skin and wound evaluation completed on December 9, 2024, for an in-house acquired moisture-associated skin damage (MASD) located on their left gluteus, lateral, and middle, with the wound measuring 68.8 cubic centimeters (cm2) x 7.3 cm x 13.4 cm. Review of Resident 88's clinical record failed to reveal any further skin and wound documentation or assessments monitoring their MASD. During an interview with the DON on January 16, 2025, at 9:42 AM, she revealed she would have expected Resident 88 to have had weekly wound and skin documentation and evaluations completed	F 0684		

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F 0684 SS=D	Continued from page 49 to monitor the MASD that was identified on December 9, 2024. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0684		
F 0686 SS=E		F 0686		

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F 0686 SS=E	Continued from page 50 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	Resident 16 has been discharged from the facility. Resident 325 had a wound evaluation completed. A comprehensive review of current residents with pressure ulcers will be conducted to ensure that weekly wound evaluations are completed and Enhanced Barrier Precautions are followed as per policy. The facility will take the further steps to ensure that the problem does not re-occur by in-servicing licensed nursing on FTag 686 as well as IC308 Enhanced Barrier Precautions Compliance will be monitored by the Director of Nursing/Designee using the Pressure Ulcer Wound Audit and Enhanced Barrier Audit to review 5 residents weekly x 3 weeks and monthly x 2 months with audit results being forwarded to the QAA committee to determine the need for further follow up/monitoring.	Completion Date: 03/03/2025 Status: APPROVED Date: 02/03/2025
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F 0686 SS=E	Continued from page 51 Based on observations, clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to ensure treatment and services, consistent with professional standards, to promote healing and prevent infection for two of six residents reviewed for pressure ulcers (Residents 16 and 325). Findings include: Review of facility policy, titled "NSG236 Skin Integrity and Wound Management", with a last reviewed and revised date of October 15, 2024, revealed "6. The licensed nurse will: 6.5 Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with any unanticipated decline in wounds." Review of Resident 16's clinical record revealed diagnoses that included chronic diastolic congestive heart failure (heart failure that occurs when the heart does not relax properly between beats causing the heart to be unable to pump an adequate amount of	F 0686		

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F 0686 SS=E	Continued from page 52 blood to the body), chronic respiratory failure (long term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body), and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). Review of Resident 16's clinical record revealed that they were transferred to the hospital on January 9, 2025, to be evaluated for mental status change, nausea, vomiting, and not eating. Review of Resident 16's physician orders at time of hospital transfer revealed an order for Wound on sacral area: Cleanse with wound cleanser, pat dry and apply medihoney and foam border dressing. Change every other day or as needed for soilage or dislodgement, dated November 26, 2024. Review of Resident 16's clinical record progress notes revealed a nursing note by a Licensed Practical Nurse dated September 27, 2024, at 12:16 PM, that indicated the Resident was noted to	F 0686		

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F 0686 SS=E	<p>Continued from page 53</p> <p>"have open area in buttock, and noted blood, saw it small open wound on middle sacrum" and that the Registered Nurse Supervisor and was notified and a note was placed on the doctor's book.</p> <p>Review of Resident 16's clinical record progress notes revealed a nursing note by a Registered Nurse dated September 27, 2024, at 1:02 PM, that indicated that a wound care order was obtained. The note further indicated "Wound and skin system is down, unable to take new pictures currently will follow up."</p> <p>Review of Resident 16's clinical record revealed a wound specialist consultation note dated October 1, 2024, that indicated that the Resident was consulted for wound prevention. The note further indicated "There is no inflammation, rash, wounds, or other lesions of significance."</p> <p>Review of Resident 16's clinical record progress notes revealed a nursing note by a Registered Nurse dated October 10, 2024, at 3:39 PM, indicated the</p>	F 0686		

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F 0686 SS=E	Continued from page 54 Resident "does get small sore area in the sacrum due to [their] incontinence, current treatment with medihoney and covered dressing." Review of Resident 16's Skin and Wound Evaluations revealed that wound evaluations and pictures of their Stage 2 pressure injury were documented on August 23 and 30, 2024; September 5, 2024; October 1 and 8, 2024; November 5 and 29, 2024; and December 10, 2024. All documented evaluations indicated that the wound was stable or improving. Review of Resident 16's Treatment Administration Records from September 2024 through January 8, 2024, revealed that all ordered treatments were provided except when Resident 16 refused. Resident 16 had refused wound care on January 7 and 8, 2024, and that wound care was not provided prior to their transfer to the hospital for an acute change in condition on January 9, 2024. Review of Resident 16's hospital records dated	F 0686		

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F 0686 SS=E	<p>Continued from page 55</p> <p>January 9, 2025, indicated that the Resident had chronic sacral wound(s) buttock avulsion (wound in which skin layers are missing) from being in a moist environment and a pressure ulcer. The wound was described as having approximated edges; being brown, red, yellow in color; with a foam dressing in place that was dry. No measurements or staging of the wound was documented.</p> <p>During a staff interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on January 16, 2025, at 9:42 AM, the DON indicated that she had no additional information to provide regarding Resident 16's pressure ulcer. In addition, she confirmed that weekly wound evaluations to include measurements were not completed as per facility policy and that she would expect them to be completed weekly and documented.</p> <p>Review of Resident 325's clinical record on January 13, 2025, revealed diagnoses that included stage two chronic kidney disease (decreased ability of</p>	F 0686		

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F 0686 SS=E	Continued from page 56 kidneys to filter toxins from the blood) and diabetes mellitus type II (decrease in the body's ability to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment). Review of Resident 325's clinical record section, titled "Wound Evaluation", revealed that an assessment by facility staff on January 8, 2024, revealed Resident 325 had a stage 3 pressure ulcer (wound that extends below the skin to the underlying tissue but does not expose bone or connective tissue) to the sacrum which was present upon admission. Review of facility policy, titled "IC308 Enhanced Barrier Precautions", last reviewed October 15, 2024, revealed it stated, "Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce the transmission of novel or multi-drug resistant organisms. It employs targeted personal protective equipment (PPE) use during high contact patient/resident [sic] activities."	F 0686		

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F 0686 SS=E	Continued from page 57 Further review of the policy revealed it stated that the facility would implement enhanced barrier precautions when a resident, "Has a wound or indwelling medical device without secretions or excretions that are unable to be covered or contained and not known to be infected or colonized with any [multi-drug resistant organism]." During observation directly before wound dressing change observation for Resident 325 on January 15, 2025, at approximately 1:00 PM, it was observed that posted on the wall outside Resident 325's room was a sign which indicated that enhanced barrier precautions were in effect for a resident(s) inside the room (Resident 325). The sign included instructions to utilize personal protective equipment with care (gloves, gown, face mask). Under the sign it was observed that a multi-drawer tote was placed which contained gloves, N-95 masks, and gowns. During wound dressing observations for Resident 325 on January 15, 2025, at approximately 1:10 PM, Employee 9 was observed performing a	F 0686		

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F 0686 SS=E	Continued from page 58 dressing change on Resident 325's stage three pressure ulcer without wearing a gown as indicated for enhanced barrier precautions. During a staff interview on January 16, 2025, at approximately 11:00 AM, DON revealed Employee 9 should have had a gown on, per enhanced barrier precautions, while performing the wound dressing change for Resident 325. During wound dressing observations for Resident 325 on January 15, 2025, at approximately 1:10 PM, Employee 9 was observed performing hand hygiene and then donning gloves prior to the dressing change. After donning gloves, Employee 9 was observed preparing the dressing change area during which Employee 9 was observed using her gloved hand to touch Residents 325 used bed linen (unclean surface), the incontinence brief that Resident 325 was wearing, and used each gloved hand to grab and slightly raise the sleeves of the shirt Employee 9 was wearing (unclean surface). Employee 9 was then observed removing Resident	F 0686		

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F 0686 SS=E	Continued from page 59 325's prior dressing without performing hand hygiene and placing new, clean gloves on. After cleansing the wound, Employee 9 was observed preparing a new dressing for Resident 325's pressure ulcer. Employee 9 was observed using her gloved hands to retrieve a marker to write her initials and date on the new dressing. The marker was observed to be retrieved from the top of the medication cart, which was in the hallway, prior to the dressing change. Employee 9 did not cleanse the marker prior to handling it with her gloved hands. After marking the new dressing, Employee 9 put the marker in her pocket. Employee 9 was then observed placing the new dressing over Resident 325's wound. Employee 9 did not perform hand hygiene or change gloves after handling the unclean marker. During a staff interview on January 16, 2025, at approximately 11:00 AM, DON revealed it was the facility's expectation that Employee 9 would have performed hand hygiene and changed gloves after	F 0686		

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F 0686 SS=E	Continued from page 60 touching unclean surfaces and prior to accessing Resident 325's wound dressing. During the interview, DON confirmed that Employee 9 should have performed hand hygiene and changed gloves after handling the marker that was not cleansed with an anti-microbial agent. 28 Pa Code 201.18(b)(1) Management 28 Pa Code 211.10(c)(d) Resident care policies 28 Pa Code 211.12(d)(1)(2)(5) Nursing services	F 0686		
F 0688 SS=E		F 0688		

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F 0688 SS=E	Continued from page 61 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	Unable to retroactively correct Resident 35's palm guard not being in place. Unable to retroactively correct failure to document Restorative Nursing Programs for Resident 35, resident 40, and Resident 50. A Comprehensive review of current residents with an active order for Palm Guards will be conducted to ensure that palm guards are in place as ordered. A Comprehensive review of current residents with a restorative Nursing Program will be conducted to ensure that Restorative Program has been completed and minutes documented. The facility will take the further steps to ensure that the problem does not re-occur by in-servicing all nursing staff on F tag 688 with focus on Palm guards and restorative Programming as well as "Restorative Nursing Guidelines" Policy Compliance will be monitored by the Director of Nursing/Designee using the Palm Guard Audit and Restorative Nursing Program Audit to review 5 residents weekly x 3	Completion Date: 03/03/2025 Status: APPROVED Date: 02/03/2025

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F 0688 SS=E	Continued from page 62	F 0688	weeks then monthly x 2 months to ensure that Palm guards are in place as ordered and that Restorative Programs are being completed and documented on as ordered with audit results being forwarded to the QAA committee to determine the need for further follow up / monitoring.	

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F 0688 SS=E	Continued from page 63 Based on facility policy review, observations, clinical record review, and staff interviews, it was determined that the facility failed to ensure residents with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for three of five residents reviewed for limited range of motion (Residents 35, 40, and 50). Findings include: Review of facility policy, titled "Restorative Nursing Guidelines", dated April 1, 2024, read, in part, "Restorative nursing services (RNP) refer to interventions that promote the patient's ability to adapt & adjust to living as independently & safety as possible. It includes interventions that promote the resident's ability to attain & maintain their maximum functional potential. RNP's include, but are not limited to: Active Range of Motion (AROM) & Passive Range of Motion (PROM). Developing a RNP includes patient need identification, program design, documentation & monitoring outcomes. The program must include documentation of the number	F 0688		

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NAME OF PROVIDER OR SUPPLIER: CAMP HILL SKILLED NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1700 MARKET STREET CAMP HILL, PA 17011		
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F 0688 SS=E	Continued from page 64 of minutes spent per restorative session. Document daily restorative nursing 'tasks' include interventions provided, time in minutes that restorative nursing care was provided, and patient tolerance of nursing interventions." Review of Resident 35's clinical record revealed diagnoses that included hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting right dominant side, aphasia (language disorder that affects a person's ability to communicate), and vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults). Review of Resident 35's current physician orders revealed an order for right palm guard on at all times except for hygiene. Check skin daily every shift, dated July 17, 2024. Observations of Resident 35 on January 13, 2025,	F 0688		

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F 0688 SS=E	Continued from page 65 at 11:47 AM and 12:14 PM; on January 14, 2024, at 9:24 AM and 1:31 PM; and January 15, at 9:44 AM, all revealed that Resident 35 did not have a palm guard in place in their right hand. Review of Resident 35's Treatment Administration Records from July 1, 2024, through December 31, 2024, revealed that Resident 35's palm guard was documented as being applied; however, review of Resident 35's January 2025 Treatment Administration Record failed to include the palm guard as an ordered treatment to be provided. Review of Resident 35's care plan revealed a focus for ADL [Activities of daily living or ADLs are routine tasks that each of us must perform every day to care for our bodies and ourselves independently] self-care deficit related to physical limitations with a revised date of November 7, 2024. Interventions included, but were not limited to, Passive Range of Motion to right upper extremity during ADLs dated August 13, 2024; and Restorative Dressing/Grooming: Resident will raise her arms, as	F 0688		

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F 0688 SS=E	Continued from page 66 tolerated, to assist with putting arms into clothing/gown, during AM and PM care moderate assist, with a revised date of March 20, 2024. Review of Resident 35's Restorative Nursing Program documentation from November 1, 2024, through January 15, 2025, revealed the following: Restorative Dressing/Grooming and Restorative Range of Motion were blank for day shift on November 7, 15, and 21, 2024; were blank for evening shift on November 19, 2024; were blank for day shift on December 4 and 31, 2024; were blank for evening shift on December 9 and 30, 2024; and were blank on day shift on January 9, 10, and 11, 2025; and were blank for evening shift on January 6 and 12, 2025. During a staff interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on January 16, 2025, at 12:21 PM, the DON indicated that she had no additional information to provide regarding Resident 35's palm guard not being applied as ordered. The DON	F 0688		

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F 0688 SS=E	Continued from page 67 confirmed that there were multiple occasions where there was no documentation to support that Resident 35's received their established Restorative Nursing Programs. In addition, the DON confirmed that she would expect staff to have provided Resident 35 their programs and to have applied that their palm guard as ordered. Review of Resident 40's clinical record revealed diagnoses that included muscle weakness and contracture (when muscles or joints tighten or shorten reducing your range of motion). Review of Resident 40's occupational therapy discharge summary on November 3, 2023, revealed he was discharged from therapy services on that date and referred to a RNP program. Review of Resident 40's care plan revealed a focus area of "At risk for loss of range of motion related to physical limitations", created on October 14, 2020, with an intervention for "Restorative Passive ROM: to bilateral hands (5 reps, twice a day) as tolerated,	F 0688		

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F 0688 SS=E	Continued from page 68 during care", last revised November 18, 2024. Review of Resident 40's clinical record failed to reveal documentation noting Resident 40's RNP program minutes or tolerance. During an email correspondence with the DON on January 15, 2025, at 9:27 AM, she revealed Resident 40's RNP program was 'corrected.' Interview with Employee 11 (Licensed Practical Nurse) on January 16, 2025, at 10:51 AM, revealed the facility had a change in electronic systems, which caused Resident 40's RNP program to not automatically carry over to documentation, so his RNP program documentation was not captured for the duration of the program. During an interview with the DON on January 16, 2025, at 12:20 PM, she revealed she would expect RNP program minutes and tolerance to be documented per facility policy.	F 0688		

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F 0688 SS=E	<p>Continued from page 69</p> <p>Review of Resident 50's clinical record revealed diagnoses that included hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting left non-dominant side, muscle weakness, and other abnormalities of gait and mobility.</p> <p>Review of Resident 50's care plan revealed a care plan focus for being at risk for loss of range of motion related to physical limitations last revised on August 14, 2024, with interventions that included Restorative Active Range of Motion to right upper extremity before every meal 2 sets of 5 repetitions revised November 5, 2024; Restorative Passive Range of Motion to left upper extremity with ADL's/Care 2 sets of 5 repetitions, revised November 5, 2024.</p> <p>Review of Resident 50's care plan also revealed a care plan focus for ADL self-care deficit evidenced by weakness related to physical limitations revised</p>	F 0688		

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F 0688 SS=E	Continued from page 70 August 14, 2024, with interventions that included Restorative Bed Mobility: Moderate assist with moving to and from lying position, Moves side to side, while in bed revised May 22, 2024; Restorative Active-Assisted Range of Motion to lower extremities 2 sets of 5 repetitions with moderate assist, dated September 24, 2024; and Restorative Transfer: Transfer from bed to chair, Transfer from w/c [wheelchair]to standard chair, Transfer from chair to bed, Transfer to/from shower chair extensive assist of 2 dated September 24, 2024. Review of Resident 50's Restorative Nursing Program documentation from November 1, 2024, through January 15, 2025, revealed the following: Restorative Bed Mobility, both Restorative Range of Motion programs, and Restorative Transfers were blank on day shift on December 4, 9, 13, 18, 24, and 26, 2024; were blank on evening shift December 30, 2024; were blank on day shift on January 3 and 6, 2025; and were blank on evening shift on January 12, 2025.	F 0688		

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F 0688 SS=E	Continued from page 71 During a staff interview with the NHA and DON on January 16, 2025, at 12:21 PM, the DON confirmed that there were multiple occasions where there was no documentation to support that Resident 50 received their established Restorative Nursing Programs and that she would expect staff to have provided Resident 50 their programs. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services	F 0688		
F 0710 SS=D		F 0710		

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F 0710 SS=D	Continued from page 72 483.30(a)(1)(2) Resident's Care Supervised by a Physician §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by:	F 0710	Resident 325 had orders placed for care of the Sacral Pressure Ulcer and Foley Catheter and did not have any adverse affects from the delay in orders. A Comprehensive review of all current residents with Pressure Ulcers and/or Foley Catheters will be conducted to ensure that wound treatment orders and foley catheter orders are in place as ordered by MD. The facility will take further steps to ensure that the problem does not re-occur by in-servicing licensed Nursing staff on F Tag 710 with a focus on Pressure Ulcer treatment and Foley catheter orders and re-educating licensed nurses on ensuring that wound care orders and Foley catheter orders are entered on admission. Compliance will be monitored by the Director of Nursing/Designee using Wound Treatment and Foley Catheter Audit to review all new admissions weekly x 3 weeks then a random audit of 5 admissions	Completion Date: 03/03/2025 Status: APPROVED Date: 02/04/2025

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F 0710 SS=D	Continued from page 73	F 0710	monthly x 2 months to ensure that wound treatment orders and foley catheter orders are in place as ordered, with audit results being forwarded to the QAA committee to determine the need for further follow up/monitoring.	

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F 0710 SS=D	Continued from page 74 Based clinical record review, hospital record review, and staff interview, it was determined that the facility failed to ensure the physician provided orders for the resident's immediate care and needs for one of 24 residents reviewed (Resident 325). Findings include: Review of Resident 325's clinical record on January 13, 2025, revealed diagnoses that included stage two chronic kidney disease (decreased ability of kidneys to filter toxins from the blood), diabetes mellitus type II (decrease in the body's ability to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment), and a stage three pressure ulcer to the sacrum (wound of the skin that can extend to the deeper layers of the skin caused by pressure over a bony prominence). Review of Resident 325's clinical record revealed that Resident 325 was admitted to the facility from the hospital on January 7, 2025.	F 0710		

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F 0710 SS=D	<p>Continued from page 75</p> <p>Review of hospital documentation revealed that while Resident 325 was in the hospital, Resident 325 had a foley catheter inserted (tube inserted into the bladder to drain urine from the bladder) and Resident 325 was assessed as having a stage II pressure ulcer to the sacrum which required treatment.</p> <p>Review of Resident 325's clinical record revealed a facility document titled, "Transition of Care," which was dated January 7, 2025, that indicated Resident 325 was being admitted from the hospital.</p> <p>Review of the document revealed staff had documented, "stage 2 sacral [wound]," and "foley" under the section titled, "Reason for Hospitalization." Further, under section titled, "Devices/Special Treatment" the box labeled, "Foley Catheter" was marked.</p> <p>Review of Resident 325's interdisciplinary progress notes revealed an initial assessment documented on January 7, 2025, at 4:48. The initial assessment</p>	F 0710		

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F 0710 SS=D	Continued from page 76 conducted by Employee 10 (Registered Nurse), confirmed that Resident 325 was admitted with a foley catheter in place and a wound to the sacrum. Review of Resident 325's clinical record section titled "Wound Evaluation", revealed that an assessment by facility staff on January 8, 2024, revealed Resident 325 had a stage 3 pressure ulcer (wound that extends below the skin to the underlying tissue but does not expose bone or connective tissue) to the sacrum which was present upon admission. Review of Resident 325's physician orders revealed that Resident 325 did not have orders for treatment to the sacral pressure ulcer upon admission. Review of the order for treatment to Resident 325's sacral pressure ulcer revealed it was ordered on January 11, 2025, with a start date of January 12, 2025, five days after admission. Review of Resident 325's physician orders also	F 0710		

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F 0710 SS=D	Continued from page 77 revealed Resident 325 did not have orders for care and/or treatment of Resident 325's foley catheter upon admission. Review of the orders for the foley catheter, including care and treatment, revealed they were dated and started on January 13, 2025, six days after admission. During a staff interview on January 16, 2025, at approximately 12:25 PM, Director of Nursing revealed it was the facility's expectation that the physician would have provided orders for foley catheter care and wound treatment for Resident 325 upon admission on January 7, 2025. 28 Pa code 201.18(b)(1) Management 28 Pa code 211.2(d)(3) Medical director 28 Pa code 211.12(d)(1)(1)(3)(5) Nursing services	F 0710		
F 0755 SS=D		F 0755		

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F 0755 SS=D	Continued from page 78 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	Facility cannot retroactively correct cited deficiency A Comprehensive review of residents who have been discharged from the facility in the last 30 days will be conducted to ensure that "disposition of medication" form has been completed with 2 Licensed nurse signatures. The facility will take the further steps to ensure that the problem does not re-occur by in-servicing Licensed nursing staff on F Tag 755 with focus on disposition of medications as well as Facility policies, "Disposal of Medication Waste" and "Collection Receptacles for Disposal of Medications". Compliance will be monitored by the Director of Nursing / Designee using the Disposition of Medications audit form to ensure that disposition of medications were completed with 2 nurse signatures. Will review 5 discharged residents weekly x 3 weeks then monthly x 2 months, with audit results being forwarded to the QAA committee to determine the need for further follow	Completion Date: 03/03/2025 Status: APPROVED Date: 01/31/2025

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F 0755 SS=D	Continued from page 79 This REQUIREMENT is not met as evidenced by:	F 0755	up/monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395440	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/16/2025	
NAME OF PROVIDER OR SUPPLIER: CAMP HILL SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 382102		STREET ADDRESS, CITY, STATE, ZIP CODE: 1700 MARKET STREET CAMP HILL, PA 17011		
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F 0755 SS=D	Continued from page 80 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to maintain an accurate accounting of the final disposition of medications upon discharge for two of three closed records reviewed (Residents 105 and 107). Findings Include: Review of facility policy, "Disposal of Medication Waste", revised July 1, 2024, revealed, "Medications that cannot be returned to the pharmacy, discharged with the patient, or donated will be placed in medication disposal bins labeled...controlled substance waste." Review of facility policy, "Collection Receptacles for Disposal of Medications", undated, revealed, "When disposing of such controlled substances by transferring those substances into a collection receptacle, such disposal shall occur immediately, but no longer than three business days after the discontinuation of use by the resident/ultimate user.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395440	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/16/2025	
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F 0755 SS=D	Continued from page 81 Discontinuation of use includes a permanent discontinuation of use as directed by the prescriber, as a result of the resident's transfer from the long-term care facility, or as a result of death. Disposition of Controlled Medication into the receptacle should only be completed by two staff as authorized by the state. Upon discontinuation of a patient's controlled substance medication, two authorized staff must document the removal of the patient's dangerous drugs from the medication cart or storage area and record the transfer of the drugs to the medication receptacle...The record of the controlled substance removed from the medication cart, or other area for storage, for disposal shall be made on a controlled substance proof-of-use sheet." Review of Resident 105's clinical record revealed that she was discharged from the facility to the hospital on November 12, 2024. Review of Resident 105's closed record revealed four "Controlled Drug Record" forms that indicated that Resident 105 had a total of 98 (26 on one form,	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395440	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/16/2025	
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F 0755 SS=D	<p>Continued from page 82</p> <p>12 on another, 30 on another, and 30 on another) Oxycodone tablets (opioid used to treat severe pain) remaining at discharge. On each form, disposition of remaining doses was signed off by one staff person on December 31, 2024.</p> <p>During an interview with the Director of Nursing (DON) on January 16, 2025, at 12:30 PM, she revealed the expectation that two staff members should have signed off on the disposal of Resident 105's medication.</p> <p>Review of Resident 107's clinical record revealed that he was discharged to home on December 8, 2024.</p> <p>Review of Resident 107's physician orders revealed that at the time of discharge, he was prescribed oxycodone 5 mg every six hours as needed for pain.</p> <p>Review of Resident 107's closed record revealed no evidence of final disposition of the aforementioned medication.</p>	F 0755		

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F 0755 SS=D	Continued from page 83 During an interview with the DON on January 16, 2025, at 12:30 PM, she revealed that she had no additional information to provide regarding final disposition of Resident 107's medications. 28 Pa. Code 211.9(j.1)(3)(4) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0755		
F 0756 SS=D		F 0756		

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F 0756 SS=D	Continued from page 84 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	DRR for resident 29 with date of 8/11/24 was reviewed by MD and order was placed. DRR for resident 74 with date of 8/8/24 and 8/11/24 were reviewed by MD and orders placed. A Comprehensive review of DRR for the last 2 months will be reviewed to ensure that the MD has reviewed and any new orders implemented. The facility will take further steps to ensure that the problem does not re-occur by in-servicing Unit managers / RN Supervisors on F Tag 756 and facility policy "Medication Regimen Review". Compliance will be monitored by the Director of Nursing / Designee through the DRR Audit of 5 residents weekly x 3 weeks then monthly x 2 months to ensure that the DRR recommendations were reviewed with MD and acted upon, with audit results being forwarded to the QAA committee to determine the need for further follow up / monitoring.	Completion Date: 03/03/2025 Status: APPROVED Date: 02/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395440	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/16/2025
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F 0756 SS=D	Continued from page 85 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756		

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F 0756 SS=D	Continued from page 86 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that the licensed pharmacist's report of a medication irregularity was reviewed and acted upon timely for two of five residents reviewed for unnecessary medications (Residents 29 and 74). Findings include: Review of facility policy, titled "Medication Regimen Review", last reviewed October 15, 2024, read, in part, "Medication Regimen Review (MRR)" is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report and resolve medication-related problems, medication errors, or other irregularities. The findings are communicated to the Director of Nursing (DON) or designee and the medical director. These findings are documented	F 0756		

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F 0756 SS=D	Continued from page 87 and filed with other consultant pharmacist recommendations in the resident's chart. Resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician." Review of Resident 29's clinical record revealed diagnoses that included hypertension (elevated blood pressure) and anxiety disorder (mental health conditions that involve persistent and excessive feelings of fear or worry). Review of Resident 29's physician orders revealed an order for "Quetiapine Fumarate Oral Tablet 150 MG (Quetiapine Fumarate), give one tablet by mouth at bedtime for anxiety, depression, insomnia", with an original start date of July 19, 2024. Review of select facility documentation provided revealed a MRR from August 11, 2024, that read, in part, "Patient on Seroquel suggest a trial dose reduction."	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395440	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/16/2025	
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F 0756 SS=D	<p>Continued from page 88</p> <p>Further review of the aforementioned document revealed it was signed by the physician on October 31, 2024, that they were in agreement with the recommendation.</p> <p>Review of Resident 29's clinical record on January 14, 2025, failed to reveal the recommendation from August 11, 2024, was ever implemented.</p> <p>During an interview with the Director of Nursing (DON) on January 16, 2025, at 12:21 PM, revealed she would have expected Resident 29's MRR to have been responded to timely by the physician and for the recommendation to have been implemented.</p> <p>Review of Resident 74's clinical record revealed diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things), anxiety disorder (a persistent feeling of worry, nervousness, or unease), and dementia (a chronic disorder of the mental processes caused by brain disease, marked</p>	F 0756		

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F 0756 SS=D	<p>Continued from page 89</p> <p>by memory disorders, personality changes, and impaired reasoning).</p> <p>Review of Resident 74's physician orders revealed an order for "Quetiapine Fumarate Oral Tablet 200 MG (Seroquel- Antipsychotic Medication), Give 200 mg orally at bedtime for depression", with a start date of August 3, 2024.</p> <p>Review of select facility documentation provided revealed a MRR from August 8, 2024, that read, in part, "Recommendation: Routine antipsychotic use must be evaluated by MD on admission for potential dose reduction or discontinuation. Please provide rationale for use with diagnosis of depression."</p> <p>Further review of the aforementioned document failed to reveal the recommendations were reviewed by the physician or acted upon.</p> <p>Review of select facility documentation provided revealed a MRR from August 11, 2024, that read, in part, "Patient on Seroquel suggest a trial dose</p>	F 0756		

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F 0756 SS=D	Continued from page 90 reduction." Further review of the aforementioned document revealed it was signed by the physician on October 29, 2024, that they were in agreement with the recommendation. Review of Resident 74's clinical record on January 14, 2025, failed to reveal the recommendation from August 11, 2024, was ever implemented. Interview with the DON on January 16, 2025, at 12:17 PM, revealed she would expect MRRs to be reviewed by nursing and/or physician and implemented timely, if applicable. 28 Pa. Code 211.2(d)(3) Medical Director 28 Pa Code 211.9(a)(1) Pharmacy Services 28 Pa. Code 211.12(d)(3)(5) Nursing Services	F 0756		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 91 483.45(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	Expired COVID test kit from Arcadia was discarded. Insulin Degludec pen, Insulin Aspart pen, and Medline Liquid Active Protein on Third Floor were discarded. A Comprehensive review of medication carts will be conducted to ensure that all Insulin Pens and Medline Liquid Active Protein are dated when opened and that there are no expired COVID test kits. The facility will take further steps to ensure that the problem does not re-occur by in-servicing all licensed nursing staff on F Tag F761 with a focus on Insulin Pens and Medline Liquid Active Protein as well as expired medications. Compliance will be monitored by the Director of Nursing / Designee using the Label/Storage of Drugs Audit through 5 random audits weekly x 3 weeks then monthly x 2 months to ensure that there are no expired COVID kits and Insulin Pens/Medline Liquid Active Protein has an open date, with audit results being forwarded to the QAA committee to determine the need for	Completion Date: 03/03/2025 Status: APPROVED Date: 02/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395440	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/16/2025
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F 0761 SS=D	Continued from page 92	F 0761	further follow up / monitoring.	

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F 0761 SS=D	Continued from page 93 Based on observations, facility policy review, review of medication data sheets, and staff interviews, it was determined that the facility failed to discard expired medications in one of three medication carts (Arcadia); and failed to properly label drugs and biologics in one of three medication carts (3rd floor short hall cart). Findings include: Review of facility policy, titled "Storage of Medications", with a last review date of October 15, 2024, revealed, "12. [in part] Note the date on the label for insulin vials and pens when first used;" and "14. [in part] Outdated ...medications are immediately removed from stock, disposed of according to procedures." Review of insulin degludec (a long-acting insulin used to manage diabetes) medication data sheet from Drugs.com revealed that this brand of insulin should be used or discarded within 56 days of opening.	F 0761		

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F 0761 SS=D	Continued from page 94 Review of insulin aspart (a fast-acting insulin used to lower blood sugar levels) medication data sheet from Drugs.com revealed that this brand of insulin should be used or discarded within 28 days of opening. Review of Medline Liquid Active Protein data sheet on Medline.com revealed that the supplement should be used or discarded within three months of opening. Observation of the Arcadia unit medication cart with Employee 2 (Licensed Practical Nurse) on January 14, 2025, at 10:16 AM, revealed an unopened box of OHC COVID tests (two) with an expiration date December 30, 2023. Employee 2 confirmed the tests were expired and indicated that they would discard them. Observation of the 3rd floor short hall medication cart with Employee 3 (Graduate Practical Nurse) on January 14, 2025, at 10:27 AM, revealed two	F 0761		

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F 0761 SS=D	<p>Continued from page 95</p> <p>insulin degludec pens, one insulin aspart pen, and a bottle of Medline Liquid Active Protein supplement without open dates indicated. Employee 3 confirmed the items were not dated when opened.</p> <p>During a staff interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on January 15, 2025, at 11:19 AM, the DON confirmed that the COVID tests should have been discarded and that the insulin pens should have been dated when they were opened. She indicated that she would need to check on the liquid protein as she believed it to be good to the manufacturer expiration date.</p> <p>During a follow-up staff interview with the NHA and DON on January 16, 2025, at 9:42 AM, the DON confirmed that the bottle of liquid protein should have been dated when opened. The NHA and DON both confirmed that medications that have a shortened shelf life after opening should be dated.</p> <p>28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services</p>	F 0761		

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F 0812 SS=E		F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395440	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/16/2025
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F 0812 SS=E	Continued from page 97 483.60(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. All unmarked food items were immediately removed from identified areas. 2. All unmarked thickened liquids and frozen shakes were immediately discarded from identified areas. 3. The Dietary Director immediately completed a comprehensive review of all refrigerators in the facility utilized by staff. 3. Dietary Director or Designee will provide re-education regarding maintaining daily temperature and sanitizer solution logs for the dishwasher machine. 4. Dietary Director or Designee will use logs to monitor the sanitizer levels in the 3 compartment sink and will educate staff on appropriate sanitizer levels of the 3 compartment sink. 5. All staff will be educated on storing and labeling food brought from outside sources at the time the food is stored. 6. Dietary Director or Designee will provide re-education to Dietary Staff regarding proper labels for food storage, thickened liquids and frozen	Completion Date: 03/03/2025 Status: APPROVED Date: 02/05/2025

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F 0812 SS=E	Continued from page 98	F 0812	shakes. 7. Compliance will be monitored by the Dietary Director or Designee through audits on temperature logs and sanitizer solution logs, daily for 30 days, and then 3x per week for 3 months. 8. Findings will be reported to the QAA Committee to determine the need for further audits.	

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F 0812 SS=E	Continued from page 99 Based on facility policy reviews, observations, and staff interviews, it was determined that the facility failed to store food and utilize kitchen equipment in accordance with professional standards for food service safety in the main kitchen and one of three nourishment areas. Findings include: Based on facility policy, titled "Food and Nutrition Services 'Use By' Dating Guidelines", last reviewed October 15, 2024, read, in part, "Guidelines apply regardless of storage location (e.g. kitchen, pantries, etc.). Thickened liquids- 'use by' date seven days after opening. Frozen shakes 'use by' date of fourteen days once thawed- use labels for individual items when removed from the carton." Based on facility policy, titled "Food Brought in for Patients/Residents", last reviewed October 15, 2024, read, in part, "Food brought to residents by family or visitors will be handled and stored in a safe and sanitary manner. Food items that require	F 0812		

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F 0812 SS=E	Continued from page 100 refrigeration must be labeled with a resident's name and date the food was brought in. Food will be held in refrigerator for up to three days following date on label and will be discarded by staff upon notification to resident." Observation of the three-compartment sink in the main kitchen on January 13, 2025, at 9:15 AM, failed to reveal a log for the concentration of the sanitizer solution. Interview with Employee 1 (Food Service Director) on January 13, 2025, at 9:16 AM, revealed they are not logging the concentration of the sanitizer solution in the three-compartment sink when in use. Observation of the dish machine in the main kitchen on January 13, 2025, at 9:17 AM, revealed the wash temperature was 130 degrees F (Fahrenheit-unit of measure), which is below the minimum safe temperature of 160 degrees F. Interview with Employee 1 on January 13, 2025, at	F 0812		

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F 0812 SS=E	Continued from page 101 9:18 AM, revealed they are not logging the temperature of the dish machine when in use. Observation in the Med Bridge pantry area refrigerator on January 13, 2025, at 9:26 AM, revealed the following from an outside source: one container of food without a date; one grocery bag of food without a date; one paper bag of food without a date; one black lunch bag of food without a name or date; one paper bag of food dated December 16, 2024, with rotten food inside; one container of rotten fruit without a name or date; one container of food dated December 31, 2024; and one open container of potato salad dated January 5, 2025. Further observation in the Med Bridge pantry area refrigerator on January 13, 2025, at 9:28 AM, revealed: two thickened cranberry juices with an open date of January 5, 2025; one container of thickened orange juice not dated with an open date; one container of thickened lemon water not dated with an open date; and one thawed frozen shake not labeled with a thawed date.	F 0812		

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F 0812 SS=E	Continued from page 102 Follow-up observation of the dish machine on January 13, 2025, at 1:16 PM, revealed the wash temperature was 122 degrees F. Interview with Employee 1 on January 13, 2025, at 1:18 AM, revealed he contacted maintenance, but they are unable to fix the machine, and the servicer has been contacted to come out as soon as possible. He then instructed the employee washing the dishes to pause and rerun the dishes through the machine after he hooks up a sanitizing solution for low temperature use. Interview with the Nursing Home Administrator on January 15, 2025, at 11:26 AM, revealed it was the facility's expectation that expired items are discarded, foods items are labeled and dated per facility policy, and kitchen equipment is utilized in accordance with professional standards. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.6(f) Dietary services	F 0812		

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F 0880 SS=D	<p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control</p> <p>§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.</p> <p>§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:</p> <p>§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;</p> <p>§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; (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;</p>	F 0880	<p>1. Medical Grade Honey has been discarded.</p> <p>2. A comprehensive review of current residents with an order for Medical Grade Honey will be conducted to ensure that it is labeled with resident name. A Comprehensive review of current licensed nursing staff will be conducted to ensure that competency for Aseptic Wound techniques was completed.</p> <p>3. The facility will take further steps to ensure that the problem does not re-occur by in-servicing licensed nursing staff on F Tag 880 with a focus on aseptic wound techniques</p> <p>4. Compliance will be monitored by the Director of Nursing/ Designee through 5 random audits weekly x 3 weeks then monthly x 2 months to ensure that Medical Grade Honey has resident name and through 3 random direct observation audits of nurses performing aseptic dressing changes to ensure that nurses are adhering to Aseptic Wound Techniques, with audit results being forwarded to the QAA committee to determine the need for further follow up/ monitoring.</p>	<p>Completion Date: 03/03/2025 Status: APPROVED Date: 02/05/2025</p>

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F 0880 SS=D	Continued from page 104 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 105 Based on clinical record review, observations, facility policy review, and staff interview, it was determined that the facility failed to implement infection control practices to help prevent the development and transmission of infectious diseases for one of one treatment cart observed (Third floor treatment cart). Findings include: Review of facility policy, titled "Infection Prevention and Control Program Description", last reviewed October 15, 2024, revealed it stated, "...Implementation of Control Measures and Precautions includes basics such as hand hygiene, Standard and Transmission Based Precautions, cleaning/disinfecting equipment and measures to protect persons [sic] from communicable diseases or infections." Review of Resident 325's clinical record on January 13, 2025, revealed diagnoses that included stage two chronic kidney disease (decreased ability of	F 0880		

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F 0880 SS=D	Continued from page 106 kidneys to filter toxins from the blood), diabetes mellitus type II (decrease in the body's ability to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment), and a stage three pressure ulcer to the sacrum (wound of the skin that can extend to the deeper layers of the skin caused by pressure over a bony prominence). Prior to wound dressing observations for Resident 325 on January 15, 2025, at approximately 1:10 PM, Employee 9 was observed retrieving a box of medical grade honey (used to promote healing and prevent infection) from the unit treatment cart. During Resident 325's dressing change observation, Employee 9 was observed placing the box of medical grade honey on Resident 325's bed-side table (an unclean surface), then opening the box, removing the seal of the tube of medical grade honey, and applying the medical grade honey on swabs to be placed on Resident 325's wound. Employee 9 replaced the tube of medical grade honey in the manufacturer's box.	F 0880		

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F 0880 SS=D	<p>Continued from page 107</p> <p>Upon completion of the dressing change, Employee 9 was observed exiting Resident 325's room holding the box of medical grade honey with the right hand and a bag containing soiled dressing supplies in the left hand. Employee 9 then went to the soiled utility room, partially entered the soiled utility room, and discarded the bag of soiled dressing supplies into a trashcan after making contact with the lid of the soiled utility room trash can.</p> <p>Employee 9 was then observed returning the box of medical grade honey to the treatment cart drawer without cleansing the box or tube. Employee 9 did not place the box of medical grade honey in a clean container prior to storing it in the treatment cart drawer, nor did Employee 9 mark the box or tube of the medical grade honey with any indication that the treatment supply was utilized for Resident 325.</p> <p>During a staff interview on January 16, 2025, at approximately 11:00 AM, Director of Nursing revealed it was the facility's expectation that</p>	F 0880		

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F 0880 SS=D	Continued from page 108 Employee 9 would have labeled the medical grade honey with Resident 325's name to ensure it would not be used on a separate resident. 28 Pa code 211.12(d)(1)(5) Nursing services	F 0880		
F 0881 SS=D		F 0881		

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F 0881 SS=D	Continued from page 109 483.80(a)(3) Antibiotic Stewardship Program §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:	F 0881	1. Resident 98 did not have any adverse effects related to the antibiotic that was administered. Urine culture sensitivity results were reviewed with the MD who advised to not repeat the UA as resident was asymptomatic and already completed the ordered antibiotic. 2. A Comprehensive review of all current residents on an antibiotic for a positive Urinary Tract Infection will be reviewed to ensure that Culture results have been reviewed with the MD timely and that appropriate Medication is in place. 3. The facility will take further steps to ensure that the problem does not re-occur by in-servicing licensed nursing staff on F Tag 881 with a focus on UTIs/Antibiotics as well as facility policy IC 402 Antibiotic Stewardship. 4. Compliance will be monitored by the Director of Nursing / Designee using an Antibiotic Stewardship Audit to review 5 residents weekly x 3 weeks then monthly x 2 months to ensure that UA results were reviewed with MD timely and correct	Completion Date: 03/03/2025 Status: APPROVED Date: 02/05/2025

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F 0881 SS=D	Continued from page 110	F 0881	Antibiotic is in place, with audit results being forwarded to the QAA committee to determine the need for further follow up / monitoring.	

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F 0881 SS=D	Continued from page 111 Based on clinical record review, laboratory result review, facility policy review, and resident and staff interviews, it was determined that the facility failed to ensure the facility's Antibiotic Stewardship Program was implemented for one of two residents reviewed for antibiotic use (Resident 98). Findings include: Review of facility policy, titled "IC402 Antibiotic Stewardship", last revision date of December 16, 2024, revealed the facility policy stated, "Centers will implement an Antibiotic Stewardship Program (ASP) as part of the facility's overall infection and control program ..." The policy's included purpose stated, "To reduce inappropriate antibiotic use and prevent the development of antibiotic-resistant organisms." Review of the policy's "Process" section revealed the program included the following: "1. The Medical Director, [Director of Nursing],	F 0881		

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F 0881 SS=D	Continued from page 112 and Consultant Pharmacist serve as the leaders of the ASP and receive support from the Administrator and other governing officials of the Center." "1.1 The Medical director ...Sets the standards for antibiotic prescribing practices for all healthcare providers prescribing antibiotics ...Oversees adherence to antibiotic prescribing practices, and ...Reviews antibiotic use data and ensures best practices are followed." "1.3 The Consultant Pharmacist ...Reviews microbiology culture results and provides feedback to prescribers on initial antibiotic selection to let them know if it is the right drug to treat the infection or if the bacteria may be resistant to the antibiotic." "4.2 Monitoring Patients' Antibiotic Use ...Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made ..." Review of Resident 98's clinical record on January	F 0881		

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F 0881 SS=D	Continued from page 113 14, 2025, revealed diagnoses that included congestive heart failure (decreased ability of the heart to effectively pump blood throughout the body) and urinary tract infection (infection that affects any part of the urinary system). During a Resident interview on January 14, 2025, at approximately 10:45 AM, Resident 98 revealed that he was recently diagnosed with an urinary tract infection. Resident 98 stated that he did not experience any symptoms prior to or after being diagnosed with an urinary tract infection. Resident 98 revealed that, at the time of the interview, he was receiving antibiotics for the urinary tract infection. Review of Resident 98's clinical record revealed that on January 8, 2025, Resident 98 was ordered an urinary analysis (laboratory examination of the urine to identify substances that may indicate health issues), along with an urinary culture (laboratory test to determine the presence, type, and amount of bacteria) and sensitivity test (laboratory test to determine which antibiotic(s) the identified bacteria	F 0881		

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F 0881 SS=D	<p>Continued from page 114</p> <p>is susceptible to or resistant to) due to urinary retention after the removal of a urinary catheter (tube inserted into the bladder to facilitate the draining of urine).</p> <p>Review of the urinalysis completed on January 8, 2025, for Resident 98 revealed that Resident 98 had indication of a possible urinary tract infection. Written on the urinary analysis laboratory results was, "Sent to [attending physician]. Cipro 500 mg [twice a day for seven days]."</p> <p>Review of Resident 98's physician orders revealed that on January 8, 2025, Resident 98 had an order for Cipro (generic name - ciprofloxacin; an antibiotic used to treat infection) 500 milligrams (mg - metric unit of measure) twice a day for seven days, initially dated January 8, 2025, and revised on January 9, 2025.</p> <p>Review of Resident 98's medication administration record revealed Resident 98 started the antibiotic on the morning of January 9, 2025.</p>	F 0881		

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F 0881 SS=D	Continued from page 115 Review of the laboratory's urine culture, which was verified by the laboratory on January 9, 2025, revealed it stated, "50,000 to 100,000 cfu/ml [cfu - colony-forming unit; ml - milliliters, combined to indicate the number of bacteria that can grow from a sample] Presumptive [methicillin-resistant Staphylococcus aureus - bacteria that is resistant to some antibiotics that can cause serious illness] ...Please refer to final report for confirmatory susceptibility to Oxacillin [antibiotic] ...Susceptibility to follow." Review of the urine culture report revealed it was signed and dated on January 10, 2025, and included a written statement of, "On Cipro [follow-up] final results." Review of Resident 98's urine culture and sensitivity report, which had a laboratory verification date of January 10, 2025, revealed that the bacteria identified in Resident 98's urine was listed as resistant to ciprofloxacin, oxacillin, and other antibiotics. The report identified the bacteria was susceptible to nitrofurantoin, rifampin, tetracycline,	F 0881		

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F 0881 SS=D	Continued from page 116 tigecycline, and vancomycin (antibiotics used to treat infections). Review of the laboratory result sheet revealed it was not initialed, indicating it had not been reviewed. Review of Resident 98's clinical record revealed there was no change in Resident 98's medication as a result of the sensitivity report, which indicated that the bacteria was resistant to the prescribed antibiotic. As of January 16, 2025, at 12:00 PM, review of available documentation revealed no documented clinical rationale for the continued use of cipro to treat Resident 98's urinary tract infection. During a staff interview on January 16, 2025, at approximately 12:25 PM, Director of Nursing stated it was the facility's expectation that antibiotic use is monitored and adjusted with the use of sensitivity test, per the facility's Antibiotic Stewardship Program.	F 0881		

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F 0881 SS=D	Continued from page 117 28 Pa code 201.18(b)(1)(3) Management 28 Pa code 211.2(d)(3)(5) Medical director 28 Pa code 211.12(d)(3)(5) Nursing services	F 0881			

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P 1700	<p>Prevention, control and surveillance of tuber</p> <p>(b) Recommendations of the Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services (HHS) shall be followed in screening, testing and surveillance for TB and in treating and managing persons with confirmed or suspected TB.</p> <p>This REGULATION is not met as evidenced by:</p>	P 1700	<ol style="list-style-type: none"> 1. CDC recommendations were not followed for screening, testing and surveillance for TB. DON provided TB testing and assessment and symptom evaluation for Employee #5 and Employee # 6. 2. Human Resources Director or Designee will complete a comprehensive review of all new hire staff from the last 30 days to ensure TB testing, assessment and screening for symptoms is current. 3. Human Resources Director or Designee will provide re-education to management staff regarding CDC guidelines and the facility policy on "Tuberculosis Screening." 5. Human Resources Director or Designee will complete an audit of new hire employees 3x per week for 3 months to ensure compliance. 6. Findings will be reported to the QAA Committee to determine the need for further audits. 	<p>Completion Date: 03/03/2025</p> <p>Status: APPROVED</p> <p>Date: 02/03/2025</p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

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P 1700	<p>Continued from page 1</p> <p>Based on Centers of Disease Control's (CDC) guidance, facility policy review, personnel file review, and staff interview, it was determined that the facility failed to follow the Centers for Disease Control and Prevention's guidelines for screening and testing of new employees for two of five new hires reviewed (Employees 5 and 6).</p> <p>Findings include:</p> <p>Review of the Centers For Disease Control's (CDC) current "Clinical Testing Guidance for Tuberculosis: Health Care Personnel", dated December 15, 2023, revealed it stated, "All U.S. health care personnel should be screened for TB upon hire (i.e., preplacement) ...TB [tuberculosis] screening includes: A baseline individual TB risk assessment; TB symptom evaluation; a TB test (e.g., TB blood test or TB skin test), and Additional evaluation for TB disease as needed."</p> <p>Review of facility policy, "Tuberculosis Screening," revealed, "TB screening is conducted for new</p>	P 1700		

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P 1700	Continued from page 2 employees including a symptom evaluation, an individual TB risk assessment, and a screening test...for those without documented prior TB Disease or Latent TB Infection." Review of Employee 5's (Nurse Aide) personnel file revealed a hire date of September 24, 2024. Further review revealed Employee 5 had a TB skin test completed in September 2023, but did not have a TB (tuberculosis - serious bacterial lung infection) skin or blood test, as indicated by CDC guidance, upon hire. Review of Employee 6's (Nurse Aide) personnel file revealed a hire date of December 3, 2024. Further review revealed that Employee 6 had a TB skin test completed in September 2024, but did not have a TB skin or blood test, as indicated by CDC guidance, upon hire. During an interview with the Nursing Home Administrator on January 16, 2025, at 12:31 PM, she stated that the facility was not requiring another	P 1700		

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P 1700	Continued from page 3	P 1700		
P 4920	<p>skin test if one had been done within a year of hire.</p> <p>Dietary Services.</p> <p>(a) Menus shall be planned and posted in the facility or distributed to residents at least 2 weeks in advance. Records of menus of foods actually served shall be retained for 30 days. When changes in the menu are necessary, substitutions shall provide equal nutritive value.</p> <p>This REGULATION is not met as evidenced by:</p>	P 4920	<p>Two weeks of menus were immediately posted for residents</p> <p>2. Dietary Director or Designee will provide education regarding the requirement for two weeks of menus to be posted.</p> <p>3. Compliance will be monitored by the Dietary Director or Designee through audits on two weeks in advance menu posting, daily for 30 days, and then 3x per week for 3 months.</p> <p>4. Findings will be reported to the QAA Committee to determine the need for further audits.</p>	<p>Completion Date: 03/03/2025</p> <p>Status: APPROVED</p> <p>Date: 02/03/2025</p>

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P 4920	Continued from page 4 Based on observation and staff and resident interviews, it was determined that the facility failed to post menus in the facility or distribute to residents at least two weeks in advance for four of four residents interviewed (Residents 8, 19, 77, and 81). Findings include: Observations during initial tour of the facility on January 13, 2025, between 9:25 AM and 9:35 AM, revealed that all three skilled nursing units only had the menu for the current week of January 12-18, 2024, posted/available on the unit. Interview with Resident 19 on January 13, 2025, at 10:03 AM, revealed she does not receive copies of the menus. Interview with Resident 8, 77, and 81 on January 14, 2025, at 11:04 AM, revealed they are not provided two weeks of menus in advance. Interview with Nursing Home Administrator on	P 4920		

Pennsylvania Department of Health

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P 4920	Continued from page 5 January 16, 2025, at 9:20 AM, revealed she would expect dietary services to post menus in the facility or distribute to residents at least two weeks in advance.	P 4920			



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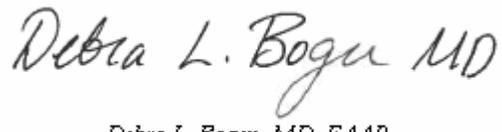
CAMP HILL SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 382102

SURVEY EXIT DATE: 01/16/2025

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**

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