

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395563	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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NAME OF PROVIDER OR SUPPLIER: MORRISONS COVE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE: 429 SOUTH MARKET STREET MARTINSBURG, PA 16662
STATE LICENSE NUMBER: 133702	

(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 0000	INITIAL COMMENT	F 0000		
F 0584 SS=D	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and Civil Rights Compliance survey completed on January 24, 2025, it was determined that Morrisons Cove Home was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0584		

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 0584 SS=D	Continued from page 1 483.10(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	The wall repairs for both R53 and R61 have been completed. A house-wide audit will be conducted to identify other residents' rooms in need of repair. A new process referred to as Room Rounds will be initiated to ensure the repairs needed are identified quickly. The Nursing Home Administrator or designee will audit 5 rooms a week times 4 weeks. Audits will be reviewed by the Quality Assurance Performance Improvement committee for results, areas for improvement and/or continued auditing.	Completion Date: 03/14/2025 Status: APPROVED Date: 02/11/2025

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F 0584 SS=D	Continued from page 2 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		

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F 0584 SS=D	Continued from page 3 Based on observations and staff interviews, it was determined that the facility failed to provide a clean, homelike environment for two of 33 residents reviewed (Residents 53, 61). Findings include: The facility's policy titled admissions, dated November 7, 2024, revealed that the policy objective was to provide a safe, clean and homelike environment for residents within 72 hours of admission. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 53, dated December 20, 2024, revealed that the resident was severely cognitively impaired, had clear speech, was usually understood and usually understands, required assistance with daily care needs, and had diagnoses that included sacral wounds and multiple sclerosis.	F 0584		

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F 0584 SS=D	Continued from page 4 Observations in Resident 53's room on January 24, 2025, at 1:00 p.m. revealed that an area on the dry wall behind the resident's bed, measuring approximately seven inches long by ten inches wide, with multiple scratches, gouges and nicks in it, and the paint was coming off in several areas. Interview with the Maintenance Director on January 24, 2025, at 1:10 p.m. confirmed that the dry wall in Resident 53's room was not homelike and needed repaired and painted. An admission MDS assessment for Resident 61, dated November 14, 2024, revealed that the resident was cognitively intact, had clear speech, was understood and could understand, required assistance with daily care needs, and had diagnoses that included depression and diabetes. A review of Resident 61's clinical record revealed that the resident was moved to a private room on October 1, 2024. Observations in Residents 61's room on January 21,	F 0584		

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F 0584 SS=D	Continued from page 5 2025, at 12:06 p.m. and January 23, 2025, at 1:48 p.m. revealed an area of dry wall behind the resident's bed that measured approximately three inches wide by five feet long, with multiple scratches, gouges and nicks where the brown layer of dry wall was exposed and the paint was coming off. Interview with Nurse Aide 1 on January 23, 2025, indicated that the previous resident had padding on the wall for safety and the damage may be from when they removed the padding from the wall. Interview with the Maintenance Director on January 23, 2025, at 2:40 p.m. confirmed that the dry wall in Resident 61's room was not homelike and needed repaired and painted. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.	F 0584		

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F 0623 SS=E	<p>483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge</p> <p>§483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c) (2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c) (1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)</p>	F 0623	<p>The facility cannot retroactively correct this deficiency. Residents discharged via emergency transfer have the potential to be affected by this ` deficient practice. The facility is initiating a notice of discharge or transfer policy. This will include notifying residents or their responsible parties in writing about the reason for the emergency transfer. Nursing staff will receive mandatory training by the Director of Nursing or designee on the new policy and the Social Services department will oversee the process to ensure compliance. The social services director will resume monthly notification to the Office of Long-term Care Ombudsman. All transfers and discharges will be audited by the administrator for 4 weeks. Audits will be reviewed by the Quality Assurance Performance Improvement committee for results, areas of improvement and/or continued auditing.</p>	<p>Completion Date: 03/14/2025 Status: APPROVED Date: 02/11/2025</p>

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F 0623 SS=E	Continued from page 7 (A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the	F 0623		

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

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F 0623 SS=E	Continued from page 9 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that a written notice regarding emergency transfer to the hospital was provided to the Office of the State Long-Term Care Ombudsman, and failed to ensure that a written notice was provided to the resident and/or the resident's responsible party regarding the reason for transfer to the hospital for five of 33 residents reviewed (Residents 1, 29, 35, 54, 59). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated November 30, 2024, revealed that the resident was cognitively intact, was usually understood, and could usually understand others. A nursing note for Resident 1, dated July 18, 2024, at 2:30 p.m., revealed that Resident 1 was experiencing chest pain. The resident said she	F 0623		

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F 0623 SS=E	Continued from page 10 wanted to go to the hospital and was sent to the hospital. A nursing note for Resident 1, dated November 20, 2024, at 9:23 a.m., revealed that Resident 1 was experiencing chest pain. The resident said she wanted to go to the hospital and was sent to the hospital. A nursing note for Resident 1, dated November 23, 2024, at 6:23 a.m., revealed that Resident 1 was admitted with congestive heart failure (CHF). There was no documented evidence that a written notice of Resident 1's transfer to the hospital was provided to the state Long-Term Care Ombudsman and that a written notice was provided to the resident and the resident's responsible party regarding the reason for transfer to the hospital. A quarterly MDS assessment for Resident 29 revealed that the resident was sometimes understood and could sometimes understand others.	F 0623		

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F 0623 SS=E	Continued from page 11 A nursing note for Resident 29, dated January 14, 2025, at 4:56 p.m., revealed that the writer was called to the resident's room at 4:46 p.m. due to a fall. The resident was lying on the floor face down parallel to his bed. The resident was yelling "get me up!" The resident had a small skin tear present on his left second finger; however, the resident did yell out in pain while leaning him forward. The physician was notified, and a new order was received to transfer the resident to the emergency room to be evaluate. A nursing note for Resident 29, dated January 15, 2025, at 3:07 p.m., revealed that the resident was going to be admitted to the hospital for 24-hour observation with diagnosis of altered mental status. There was no documented evidence that a written notice of Resident 29's transfer to the hospital was provided to the state Long-Term Care Ombudsman and that a written notice was provided to the resident and the resident's responsible party regarding the reason for transfer to the hospital.	F 0623		

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F 0623 SS=E	Continued from page 12 An admission MDS for Resident 35, dated May 8, 2024, revealed that the resident was sometimes understood and could sometimes understand others. A nursing note for Resident 35, dated July 31, 2024, at 8:06 a.m., revealed that the resident was resting in bed with his eyes closed. The resident was not easily arousable to verbal stimuli and staff had to use physical stimuli to awaken the resident. The resident was not verbal that a.m. and slightly confused, and was only oriented to self. The resident's right pupil was sluggish during the assessment. A nursing note at 9:12 a.m. revealed that the physician was aware, and orders were received to send the resident for a CT scan. A nursing note at 9:50 a.m. revealed that the resident was sent to the hospital for further evaluation. A nursing note at 2:25 p.m. revealed that the resident will be admitted for acute head injury with bleeding. There was no documented evidence that a written notice of Resident 35's transfer to the hospital was	F 0623		

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F 0623 SS=E	Continued from page 13 provided to the state Long-Term Care Ombudsman and that a written notice was provided to the resident and the resident's responsible party regarding the reason for transfer to the hospital. Interview with the Director of Nursing on January 23, 2025, at 1:40 p.m. confirmed that there was no documented evidence that a written notice of Resident 29 and Resident 35's transfers to the hospital was provided to the state Long-Term Care Ombudsman and that a written notice was provided to the residents and the resident's responsible party regarding the reason for transfer to the hospital. A quarterly MDS for Resident 54, dated September 24, 2024, revealed that the resident was usually understood, could usually understand others, and was severely cognitively impaired. A quarterly MDS for Resident 54, dated December 19, 2024, revealed that the resident was sometimes understood and could sometimes understand others. A nursing note for Resident 54, dated December 6,	F 0623		

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F 0623 SS=E	Continued from page 14 2024, at 7:57 p.m., revealed that the writer was called to the nursing desk due to a fall. The resident was witnessed to have fallen on his face from the wheelchair. The physician was notified, and a new order was received to transfer the resident to the emergency room to be evaluate. A nursing note for Resident 54, dated December 25, 2024, at 3:57 p.m. revealed that the writer was called to the the resident's room due to a change in condition. The resident was not acting right and was leaning to the right side. The physician was notified, and a new order was received to transfer the resident to the emergency room to be evaluated. There was no documented evidence that a written notice of Resident 54's transfer to the hospital was provided to the state Long-Term Care Ombudsman and that a written notice was provided to the resident and the resident's responsible party regarding the reason for transfer to the hospital. A quarterly MDS assessment for Resident 59,	F 0623		

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F 0623 SS=E	<p>Continued from page 15</p> <p>dated December 26, 2024, revealed that the resident was moderately cognitively impaired, had clear speech, was usually understood and usually understands, required assistance with daily care needs, and had diagnoses that included diabetes and heart disease.</p> <p>A nursing note for Resident 59, dated April 16, 2024, at 12:50 p.m., revealed that the resident had a fall and complained of pain in her forehead, knee, and left arm. The physician was notified, and the resident was sent to the hospital for an evaluation and was admitted.</p> <p>There was no documented evidence that a written notice of Resident 59's transfer to the hospital was provided to the state Long-Term Care Ombudsman and that a written notice was provided to the resident and the resident's responsible party regarding the reason for transfer to the hospital.</p> <p>Interview with the Director of Nursing on January 24, 2025, at 9:17 a.m. confirmed that the facility did</p>	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395563	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
NAME OF PROVIDER OR SUPPLIER: MORRISONS COVE HOME STATE LICENSE NUMBER: 133702		STREET ADDRESS, CITY, STATE, ZIP CODE: 429 SOUTH MARKET STREET MARTINSBURG, PA 16662		
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F 0623 SS=E	Continued from page 16 not provide a written notice to the above residents and/or their representative when the residents were transferred to the hospital and/or the reason for hospitalization. 28 Pa. Code 201.14(a) Responsibility of licensee.	F 0623		
F 0625 SS=D		F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395563	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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F 0625 SS=D	Continued from page 17 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	The facility cannot retroactively correct this deficiency. A house-wide audit will be conducted to ensure the bed hold policies were reviewed with resident or resident representatives. All licensed staff will be educated on the updated Bed Hold policy with emphasis on including the policy at the time of transfer and leave. The Nursing Home Administrator or designee will audit all transfers and therapeutic leaves for 4 weeks. Also, the administrator will audit 3 months of the monthly reports to the Office of the State Long-Term Care Ombudsman. Audits will be reviewed by the Quality Assurance Performance Improvement committee for results, areas for improvement and/or continued auditing.	Completion Date: 03/14/2025 Status: APPROVED Date: 02/11/2025

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F 0625 SS=D	Continued from page 18	F 0625		

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F 0625 SS=D	Continued from page 19 Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide a written notice of the facility's bed-hold policy to the resident and/or the resident's representative at the time of transfer for one of 33 residents reviewed (Resident 59). Findings include: A nursing note for Resident 59, dated March 16, 2024, indicated that the resident was transferred to the hospital and was being admitted after a change in condition. There was no documented evidence that the resident and/or the resident's representative were provided with written information about the facility's bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) at the time of the transfer to the hospital. Interview with the Director of Nursing on January 24, 2025, at 9:17 a.m. confirmed that there was no documented evidence that a written notice of the	F 0625		

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F 0625 SS=D	Continued from page 20 facility's bed hold policy was provided to Resident 59 and/or the resident's representative at the time of the resident's transfer to the hospital. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(3) Management.	F 0625		
F 0657 SS=E	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 0657	The facility corrected the care plans for residents R8, R26, R53 and R66 immediately when notified of the errors. No other care plan errors affecting other residents have been identified. All licensed staff will be re-educated on the care plan policy. Director of Nursing or designee on five care plans weekly for four weeks and then five care plans monthly for 3 months	Completion Date: 03/14/2025 Status: APPROVED Date: 02/11/2025

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F 0657 SS=E	Continued from page 21 (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		

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F 0657 SS=E	Continued from page 22 Based on review of policies, clinical records, and facility investigations, as well as staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in resident care needs for four of 33 residents reviewed (Residents 8, 26, 53, 66). Findings include: The facility's policy regarding care plans, dated November 7, 2024, indicated that nurses and interdisciplinary team members were responsible for updating the resident's care plan to reflect changes in the resident's status. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated June 13, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included dementia. A care plan for the resident, dated November 25, 2022, revealed that the resident has impaired cognitive function or impaired	F 0657		

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F 0657 SS=E	Continued from page 23 thought processes related to dementia. A nursing note for Resident 8, dated June 21, 2024, revealed that the nurse aide reported to the writer that the resident was in the bathroom of her room and when she went in to assist her, she found that resident had used Calmoseptine (used to treat and prevent minor skin irritations like those resulting from diarrhea, burns, cuts, and scrapes) on her dentures instead of her denture cream. The resident said she could not see what she was using, so the nurse aide had her rinse her mouth out, use toothpaste, and brush the inside of the mouth and tongue. Her dentures were then cleaned with toothpaste. The resident claims she did not swallow any of the Calmoseptine. Facility investigation documents for Resident 8, dated June 21, 2024, revealed that a new intervention was to remove creams kept at the bedside. As of January 22, 2025, there was no documented	F 0657		

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F 0657 SS=E	Continued from page 24 evidence that Resident 8's care plan was revised/updated to include that bedside creams should be removed. Observations of Resident 8's bathroom on January 22, 2025, at 2:00 p.m. revealed that there were two tubes of Calmoseptine in a plastic basin that also contained the resident's mouth care items. Interview with the Director of Nursing on January 22, 2025, at 3:10 p.m. confirmed that Resident 8's care plan was not revised/updated to include that bedside creams should be removed. An admission MDS assessment for Resident 26, dated December 9, 2024, indicated that the resident was cognitively impaired, and that she was medicated with an anticoagulant (blood thinner). Physician's orders for Resident 26, dated December 3, 2024, included an order for the resident to receive 20 milligrams (mg) of Xarelto (blood thinner) daily until January 1, 2025, at which time the medication would be discontinued. Resident	F 0657		

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F 0657 SS=E	<p>Continued from page 25</p> <p>26's care plan, dated December 9, 2024, revealed that the resident was medicated with a blood thinner.</p> <p>There was no documented evidence that Resident 26's care plan was updated to reflect the discontinuation of the blood thinner.</p> <p>An interview with the Director of Nursing on January 24, 2025, at 9:13 a.m. confirmed that Resident 26's care plan was not updated after the discontinuation of the blood thinner and it should have been.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 53, dated December 20, 2024, indicated that the resident was severely cognitively impaired, usually understood and usually understands, required assistance from staff for his daily care needs, and had a catheter related to the diagnosis of neuromuscular dysfunction of the bladder (nerves controlling the bladder are damaged</p>	F 0657		

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F 0657 SS=E	Continued from page 26 resulting in difficulty urinating or incontinence). Clinical notes for Resident 53, dated June 3, 2024, indicated that while performing a.m. care the aide noted a tear of the penis meatus (opening for urine) with scant bleeding. A physician's order for Resident 53, dated June 4, 2024, included an order to cleanse the penis with soap and water, pat dry and apply bacitracin every shift for skin tear to the meatus (opening for urine). A current care plan indicated treatment to the residents skin tear was ongoing; however, physician orders indicated that the treatments were discontinued on November 6, 2024. Interview with the Director of Nursing on January 22, 2024, at 9:51 a.m. confirmed that Resident 53's care plan should have been updated to reflect that the treatments to the resident's penis were discontinued, and it was not. A quarterly MDS assessment for Resident 66,	F 0657		

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F 0657 SS=E	<p>Continued from page 27</p> <p>dated September 13, 2024, indicated that the resident was moderately cognitively impaired, usually understood and usually understands, required assistance from staff for his daily care needs, and had heart failure and hypertension (high blood pressure). A care plan dated July 5, 2024, revealed that Resident 66 was at risk for falls due to deconditioning, gait and balance problems, weakness and non-compliance with transfers and ambulation.</p> <p>A fall investigation for Resident 66, dated October 30, 2024, revealed that the resident had a fall from a high bed. The immediate intervention was to remove the bed remote out of reach from the resident.</p> <p>There was no documented evidence to indicate that the fall care plan was updated to reflect that the bed remote should be kept out of his reach.</p> <p>Interview with the Director of Nursing on January 22, 2025, at 9:51 a.m. confirmed that Resident 66's</p>	F 0657		

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F 0657 SS=E	Continued from page 28 care plan should have been updated to reflect that the bed remote control should not be in reach, and it was not. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0657		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 29 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	The facility cannot retroactively correct the fall interventions but has corrected the care plan for resident R8. A year to date audit of incidents reports will be conducted to confirm suggested interventions have been initiated. All nursing staff, including agency staff and new hires will be educated on the facility care plan policy and procedures. Administrative nursing staff will be educated on the accidents and incident process. The 24-hour clinical nursing report will be reviewed by Director of Nursing or designee, daily for 2 weeks followed by random audits for 2 weeks. 5 accidents and incident reports will be reviewed weekly times 4 to confirmed interventions are in place. Audits will be reviewed by the Quality Assurance Performance Improvement committee for results, areas for improvement and/or continued auditing.	Completion Date: 03/14/2025 Status: APPROVED Date: 02/11/2025

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F 0689 SS=D	Continued from page 30 Based on review of clinical records and facility investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that a resident's environment remained as free of accident hazards as possible for one of 33 residents reviewed (Resident 8). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated June 13, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included dementia. A care plan for the resident, dated November 25, 2022, revealed that the resident has impaired cognitive function or impaired thought processes related to dementia. A care plan, dated June 14, 2024, revealed that the resident was at risk for falls related to gait/balance problems, as well as a history of non-compliance with transfers and ambulation. The resident was an assist of one staff with a gait belt and a wheeled walker for her	F 0689		

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F 0689 SS=D	Continued from page 31 transfers. Nursing notes for Resident 8, dated June 15, 16, and 17, 2025, revealed that the resident had been observed self-ambulating and that despite much education to the resident by staff on the importance of ringing her call bell and waiting for staff assistance, the resident's non-compliance with self-transfers continues. A nursing note for Resident 8, dated June 26, 2024, revealed that the writer was called to the resident's room due to a fall. The resident had tried to self-ambulate to the bathroom and fell inside of the bathroom. There was no documented evidence that any new interventions to prevent the resident from self-transferring without staff assistance were initiated prior to Resident 8's fall on June 26, 2024. Interview with the Nursing Home Administrator and the Director of Rehabilitation on January 22, 2025, at 1:12 p.m. revealed that Resident 8 was on therapy case load for strengthening and balance	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395563	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025	
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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 0689 SS=D	Continued from page 32 training in attempts to get the resident back to being independent at that time. On June 11, 2024, the resident's transfer status was changed from being independent to being a one assist. The Nursing Home Administrator confirmed that the resident was educated by staff when they observed the resident self-transferring; however, there were no new and/or revised interventions to prevent the resident from self-transferring without staff assistance initiated prior to Resident 8's fall on June 26, 2024. A nursing note for Resident 8, dated June 21, 2024, revealed that a nurse aide reported to the writer that the resident was in the bathroom of her room and when she went in to assist her, she found that resident had taken Calmoseptine (used to treat and prevent minor skin irritations like those resulting from diarrhea, burns, cuts, and scrapes) and was using it on her dentures instead of her denture cream. The resident said she could not see what she was using, so the nurse aide had her rinse her mouth out, used toothpaste, and brush the inside of the mouth and tongue. Her dentures were then	F 0689		

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F 0689 SS=D	Continued from page 33 cleaned with toothpaste. The resident claims she did not swallow any of the Calmoseptine. Facility investigation documents for Resident 8, dated June 21, 2024, revealed that a new intervention was to remove bedside creams. As of January 22, 2025, there was no documented evidence that Resident 8's care plan was revised/updated to include that bedside creams should be removed. Observations of Resident 8's bathroom on January 22, 2025, at 2:00 p.m. revealed that there were two tubes of Calmoseptine in a plastic basin that also contained the resident's mouth care items. Interview with Nurse Aide 2 on January 22, 2025, at 2:44 p.m. confirmed that there were two tubes of Calmoseptine in Resident 8's plastic bin in her bathroom. She indicated that this morning the resident rang her call bell and when she responded to the call bell, she found that the resident had	F 0689		

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F 0689 SS=D	Continued from page 34 self-transferred to the bathroom. Interview with the Director of Nursing on January 22, 2025, at 3:10 p.m. confirmed that Resident 8's Calmoseptine should not have been in the resident's room. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0689		
F 0694 SS=D		F 0694		

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F 0694 SS=D	Continued from page 35 483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0694	A medication error form will be initiated for the staff who failed to administer the normal saline flush as ordered by the physician/policy. Any resident ordered a normal saline flush is at risk for this deficiency. All licensed nursing staff will be re-educated on of the intravenous medication administration policy. The Director of Nursing or designee will conduct audits on all intravenous medication and flushes weekly times 4 weeks. Audits will be reviewed by the Quality Assurance Performance Improvement committee for results, areas of improvement and/or continued auditing.	Completion Date: 03/14/2025 Status: APPROVED Date: 02/11/2025

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F 0694 SS=D	Continued from page 36 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for the care and maintenance of intravenous catheters, failed to ensure that intravenous catheters were flushed according to facility policy, and failed to ensure that physician's orders for the care and maintenance of intravenous catheters were obtained for one of 33 residents reviewed (Resident 29). Findings include: The facility's policy regarding flushing peripheral catheter (a thin, flexible tube that is inserted into a vein to administer fluids, blood, or medications), dated November 7, 2024, indicated that peripheral intravenous (IV) catheters will be flushed prior to each infusion to assess catheter patency and function, and after each infusion to clear the catheter lumen of medication and to prevent contact between incompatible medications. Staff was to use the push-pause technique to instill the normal saline.	F 0694		

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F 0694 SS=D	<p>Continued from page 37</p> <p>Physician's orders for Resident 29, dated November 15, 2024, included an order for the resident to receive one gram (gm) of Meropenem (used to treat infections caused by bacteria) intravenously every six hours for a urinary tract infection for seven days.</p> <p>Physician's orders for Resident 29, dated November 15, 2024, and discontinued on November 24, 2024, included an order for the resident to receive a 10 milliliter (ml) normal saline flush every shift for IV maintenance until the completion of his antibiotic.</p> <p>Resident 29's Medication Administration Records (MAR's) for November 2024 revealed that there was no document evidence that staff administered the 10 ml normal saline flush during the dayshift on November 24, 2024, or during the evening shift on November 15, and 22, 2024.</p> <p>Resident 29's MAR's for November 2024 revealed</p>	F 0694		

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F 0694 SS=D	Continued from page 38 that staff administered the IV Meropenem on November 15, 2024, at 8:00 p.m.; on November 16 through 21, 2024, at 2:00 a.m., 8:00 a.m., 2:00 p.m. and 8:00 p.m.; and on November 22, 2024, at 2:00 a.m., 8:00 a.m., and 2:00 p.m.. However, there was no documented evidence that staff flushed the resident's IV catheter with normal sterile saline solution before and after the administration of the Meropenem. A nursing note for Resident 29, dated November 27, 2024, revealed that the resident's IV catheter was removed at this time. However, there was no documented evidence that Resident 29's physician was contacted for orders regarding the care and maintenance of the resident's IV catheter from November 24 through 27, 2024, when it was removed. Interview with the Director of Nursing on January 23, 2025, at 3:05 p.m. confirmed that there was no documented evidence that Resident 29's IV catheter was flushed with the 10 ml of normal saline during	F 0694		

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F 0694 SS=D	Continued from page 39 the dayshift on November 24, 2024, and during the evening shift on November 15, and 22, 2024; that there was no documented evidence that the resident's IV catheter was flushed with normal sterile saline solution before and after the administration of the Meropenem; and that there was no documented evidence that the resident's physician was contacted for orders regarding the care and maintenance of the resident's IV catheter from November 24 through 27, 2024, when it was removed. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0694		
F 0699 SS=D		F 0699		

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F 0699 SS=D	Continued from page 40 483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by:	F 0699	An assessment has been conducted for resident R62 with triggers identified. A house wide audit has been done for all residents with a Post Traumatic Stress Disorder diagnosis, all identified residents will have an assessment completed to identify triggers and interventions. Nursing and social services will be educated on a newly created Trauma Informed care policy. The Nursing Home Administrator or designee will audit new resident diagnoses and new admissions for diagnoses of post-traumatic stress for 4 weeks. Audits will be reviewed by the Quality Assurance Performance Improvement committee for results, areas for improvement and/or continued auditing.	Completion Date: 03/14/2025 Status: APPROVED Date: 02/11/2025

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F 0699 SS=D	Continued from page 41 Based on review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to ensure that residents were assessed and received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event) for one of 33 residents reviewed (Resident 62). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 62, dated December 5, 2024, revealed that the resident was cognitively intact and had diagnoses which included PTSD. A care plan for the resident, dated September 11, 2024, revealed that the resident had a potential for mood problems related to his PTSD. An interview with Resident 62 on January 22, 2025,	F 0699		

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F 0699 SS=D	Continued from page 42 at 10:38 a.m. revealed that he was a war veteran and that he had a terrible motor vehicle accident. He stated that he had some trauma from both of those life events. However, there was no documented evidence that the facility completed an assessment for a history of trauma for Resident 62 to identify specific triggers that could re-traumatize the resident. Interview with the Nursing Home Administrator on January 22, 2025, at 2:09 p.m. confirmed that there was no documented evidence of an assessment for a history of trauma being completed for Resident 62. 28 Pa. Code 211.12(a)(d)(3)(5) Nursing Services. 28 Pa. Code 211.16(a) Social Services.	F 0699		
F 0755 SS=D		F 0755		

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F 0755 SS=D	Continued from page 43 483.45(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	Immediate education was provided to the licensed staff who failed to indicate on the medication administration record that an as needed medication was given. Whole house audit will be conducted to confirm narcotics that have been signed out are initialed on the medication administration record. All licensed staff will be re-educated on the facility's controlled substance policy. The Director of Nursing or designee will audit 5 narcotic sheets a week for 4 weeks. Audits will be reviewed by the Quality Assurance Performance Improvement committee for results, areas for improvement and/or continued auditing.	Completion Date: 03/14/2025 Status: APPROVED Date: 02/11/2025

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F 0755 SS=D	Continued from page 44 This REQUIREMENT is not met as evidenced by:	F 0755		

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F 0755 SS=D	Continued from page 45 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 33 residents reviewed (Resident 54). Findings include: The facility's policy for controlled substances, dated November 7, 2024, revealed that facility staff should document the time and day of administration, amount administered, and remaining quantity. Each dose of a medication shall be initialed on the Medication Administration Record (MAR) after the medication was actually administered. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 54, dated December 19, 2024, revealed that the resident was sometimes understood, and could sometimes understand others, required assistance with all care needs, and	F 0755		

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F 0755 SS=D	Continued from page 46 had diagnosis that included depression. Physician's orders for Resident 54, dated December 4, 2024, included an order for the resident to receive 0.5 milligrams (mg) of Ativan (a narcotic anxiety medication) every six hours as needed for restlessness for 14 days. Physician's orders for Resident 54, dated December 28, 2024, included an order for the resident to receive 0.5 mg of Ativan every six hours as needed for restlessness and anxiety for 30 days. Review of the December 2024 and January 2025 controlled drug records for Resident 54 revealed that 0.5 mg of Ativan was signed out on December 9, 2024, at 4:30 a.m.; December 11, 2024, at 11:00 p.m.; and January 11, 2025, at 10:00 p.m. However, there was no documented evidence in Resident 54's clinical record, including the MAR, that the signed-out dose of the controlled medication was administered to the resident on the above-mentioned date and time.	F 0755		

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F 0755 SS=D	Continued from page 47 Interview with the Director of Nursing on January 24, 2025, at 12:15 p.m. confirmed that there was no documented evidence in the clinical records to indicate that the signed-out doses of controlled medications mentioned above were administered to Resident 54. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0755		
F 0867 SS=D		F 0867		

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F 0867 SS=D	Continued from page 48 483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including	F 0867	No specific residents and/or staff were affected by these deficiencies. Currently the core team of the Quality Assurance and Performance Improvement committee meets weekly and will work with a consultant to ensure focus on reoccurring issues. The Nursing Home Administrator and/or designee will retrain the members of the Quality Assurance and Improvement Committee on its responsibility for maintaining compliance with previously cited deficiencies. The Nursing Home Administrator and/or designee will audit open plan of corrections weekly x 4 then monthly x 2 or until substantial compliance is accomplished. Findings will be reviewed at the monthly facility Quality Assurance and Performance Improvement meeting.	Completion Date: 03/14/2025 Status: APPROVED Date: 02/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395563	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/24/2025
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STATE LICENSE NUMBER: 133702				
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F 0867 SS=D	Continued from page 49 the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the	F 0867		

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F 0867 SS=D	Continued from page 50 incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 0867		

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F 0867 SS=D	Continued from page 51 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 0867		

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F 0867 SS=D	Continued from page 52 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending January 4, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending January 24, 2025, identified repeated deficiencies related to the revision of care plans and pharmacy procedures, services, and records. The facility's plan of correction for a deficiency regarding a failure to update residents' care plans,	F 0867		

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F 0867 SS=D	Continued from page 53 cited during the survey ending January 4, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding updating residents' care plans. The facility's plan of correction for a deficiency regarding the pharmacy procedures, services, and records, cited during the survey ending January 4, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F755, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding pharmacy procedures, services, and records. Refer to F657 and F755.	F 0867		

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F 0867 SS=D	Continued from page 54 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.	F 0867		
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures	F 0880	Re-education including a return demonstration has been provided to the employee. All licensed staff will be re-educated on wound care with an emphasis on handwashing. The Director of Nursing or designee will complete 5 random auditing weekly times 4. Audits will be reviewed by the Quality Assurance Performance Improvement committee for results, areas for improvement and/or continued auditing.	Completion Date: 03/14/2025 Status: APPROVED Date: 02/11/2025

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F 0880 SS=D	Continued from page 55 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; 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.	F 0880		

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F 0880 SS=D	Continued from page 56 §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	<p>Continued from page 57</p> <p>Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper hand washing/hand hygiene was completed during wound care for one of 33 residents reviewed (Resident 53).</p> <p>Findings include:</p> <p>The facility's policy regarding wound care and hand washing/hand hygiene, dated November 7, 2024, revealed that staff were to provide wound care in a manner to decrease potential for infection and/or cross-contamination. In addition, gloves should be removed and hand hygiene done prior to moving from a dirty to clean task.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 53, dated December 20, 2024, revealed that the resident was severely cognitively impaired, had clear speech, was usually understood and usually understands, required</p>	F 0880		

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F 0880 SS=D	Continued from page 58 assistance with daily care needs, received hospice, had diagnoses that included multiple sclerosis and sacral wounds, and had a Stage 4 pressure ulcer (skin breakdown from pressure that exposes fat under the skin). Physician's orders, dated October 29, 2024, included an order to wash around the wound bed with water and antibacterial soap, pat dry, cleanse wound with a four by four (gauze sized four inches by four inches) soaked in 0.25 percent acetic acid solution, apply A and D ointment (a thick skin protective) to the peri wound, loosely pack wound bed and undermining with Aquacel Ag (a type of wound dressing that contains ionic silver), and cover with an abdominal pad and secure. Observations of Resident 53's wound care on January 23, 2025, at 11:15 a.m. revealed that Licensed Practical Nurse 3 washed her hands and put on a gown and gloves prior to placing a barrier on the bed and cleaning around the wound on the resident's sacrum with water and antibacterial soap. She then patted the area dry, cleaned the sacral wound with 0.25 percent acetic acid solution, patted	F 0880		

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F 0880 SS=D	Continued from page 59 dry, disposed of the barrier, removed her gloves, washed and dried her hands and donned new gloves, applied A and D ointment on the periphery of the wound, applied Aquacel Ag using a large Q-tip to press the dressing into the wound, and covered the wound with an abdominal pad and secured with tape. Licensed Practical Nurse 3 then touched the resident's skin below the dressing area, adjusted the resident's pillow and protective heel boots, and then used the bed controls to reposition the bed. Licensed Practical Nurse 3 then gathered the supplies, placed items into the garbage, removed her gloves, and washed her hands. Licensed Practical Nurse 3 did not remove her gloves and wash her hands after providing wound care and before adjusting Resident 53's pillow, protective heel boots, and bed controls. Interview with Licensed Practical Nurse 3 on January 23, 2025, at 11:36 a.m. confirmed that she did not remove her gloves and wash her hands after Resident 53's wound care and prior to providing care to the resident.	F 0880		

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F 0880 SS=D	Continued from page 60 Interview with the Director of Nursing on January 23, 2025, at 1:35 p.m. confirmed that Licensed Practical Nurse 3 should have removed her gloves and washed her hands prior to adjusting the pillow, protective heel boots, and bed controls, as that was considered moving from a dirty to a clean task. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.	F 0880		

Pennsylvania Department of Health

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P 5350	<p>Resident care policies.</p> <p>(a) Resident care policies shall be available to admitting physicians, sponsoring agencies, residents and the public and shall reflect an awareness of, and provision for, meeting the total medical, nursing, mental and psychosocial needs of residents.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5350	<p>An assessment has been conducted for resident R62 with triggers identified. A house wide audit has been done for all residents with a Post Traumatic Stress Disorder diagnosis, all identified residents will have an assessment completed to identify triggers and interventions. Nursing and social services will be educated on a newly created Trauma Informed care policy. The Nursing Home Administrator will audit new resident diagnoses and new admissions for diagnoses of post-traumatic stress for 4 weeks. Audits will be reviewed by the Quality Assurance Performance Improvement committee for results, areas for improvement and/or continued auditing.</p>	<p>Completion Date: 03/14/2025 Status: APPROVED Date: 02/11/2025</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

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P 5350	Continued from page 1 Based on record reviews and staff interviews, it was determined that the facility failed to ensure that there was a written policy in place for trauma informed care. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 62, dated December 5, 2024, revealed that the resident was cognitively intact and had diagnoses which included Post Traumatic Stress Disorder. A care plan for the resident, dated September 11, 2024, revealed that the resident had a potential for mood problems related to his PTSD. An interview with the Nursing Home Administrator on January 22, 2025, at 1:20 p.m. confirmed that the facility did not have a policy regarding trauma based assessments.	P 5350		



Certified End Page

MORRISONS COVE HOME

STATE LICENSE NUMBER: 133702

SURVEY EXIT DATE: 01/24/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY