STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395827	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KADIMA REHABILITATION & NURSING AT POTTSTOWN	**3031 CHESTNUT HILL ROAD POTTSTOWN, PA 19464**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, resident and staff interview, and clinical record review, it was determined that the facility failed to ensure the dignity of one of two residents reviewed for unsafe wandering and elopement (Resident 22). Findings include: Review of facility policy, entitled Resident Elopement, last revised on August 28, 2018, revealed that cognitively impaired residents with the physical ability to leave the facility without assistance, and who have demonstrated or vocalized a desire to leave the facility will be placed on a unit with an electronic monitoring system. Observation of Resident 22 on March 10, 2020, at 1:15 p.m. revealed the resident had a wanderguard (tracking device designed to prevent individual from leaving a facility) on the right ankle. Interview with Resident 22 on March 10, 2020 at 1:15 p.m. revealed that when asked why the resident had a wanderguard on, the resident stated it was in case I go outside to wander. I think most people have one who aren't in wheelchairs. Resident 22 expressed that she was allowed outside if she wished and that she also went out on leaves of absences with her family occasionally. At no time in the interview did Resident 22 express a desire to wander or leave the facility. Review of Resident 22's physician orders [REDACTED]. Review of Resident 22's quarterly MDS (Minimum Data Set - periodic assessment of resident care needs) dated February 3, 2020, indicated that resident had no cognitive impairment with a BIMS (Brief Interview for Mental Status - tool used to assess a resident's cognition level) score of 15 indicating there were no cognitive deficits. Further review of the MDS revealed that the resident exhibited zero instances of wandering in the look back period. Review of Resident 22's most recent Elopement/Wander Risk Evaluation revealed the resident had a score of 21, indicating high risk for elopement. Further review of the evaluation revealed that the answers that contributed to the high score were that the resident had a recent medication change, was independent with mobility, and was currently taking an antidepressant. The evaluation stated that the resident had no history of wandering. Review of Resident 22's clinical record revealed no documented evidence that the resident ever expressed a desire to leave the facility, no documented evidence of wandering, and no care plan in place suggesting the resident was at high risk for elopement. The facility's failure to ensure Resident 22's dignity by placing a Wanderguard on a resident with no cognitive impairment was discussed during an interview with the Regional Nursing Home Administrator on March 12, 2020, at 12:20 p.m. 28 Pa. Code 201.29(j) Resident rights
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of facility policies, clinical record review, and staff interview, it was determined that the facility failed to notify the family of a significant change for one of 16 residents reviewed (Resident 7). Findings include: Review of the facility policy labeled Resident Weights revealed that for a resident who is on monthly weights, re-weights will be obtained within 72 hours if a weight change is greater than 3%. If the weight change is validated, the licensed nurse will notify the physician and dietitian. The licensed nurse will notify the interdisciplinary team for further assessment if the weight change is significant (a weight loss or gain of 5% in a month, 7.5% in 90 days, or 10% in 6 months), and staff will notify the family. Review of Resident 7's clinical record revealed the following Diagnoses: [REDACTED]. A physician's order dated October 9, 2019, instructed staff to consult for paracentesis for comfort. The facility develped a care plan to monitor weights and notify the physician of [MEDICAL CONDITION] (a collection of fluid). Review of Resident 7's clinical record revealed that on February 24, 2020, a weight of 94.5 pounds was obtained and on March 6, 2020 a weight of 119.5 pounds was obtained (a 25-pound weight gain). This was a 21% significant weight gain in 10 days. A reweigh confirmed the weight. There was no documentation that the physician was notified of the 25-pound weight gain. Further review of Resident 7's clinical record revealed that the facility did not inform the physician or family of the significant weight change. An interview with the Regional Nursing Home Administrator, Employee E2, on March 12, 2020, at 1:00 p.m. confirmed that the facility did not inform the physician or family of the significant weight gain. 28 Pa. Code 201.18(b)(1) Management Previously cited 3/16/19 28 Pa. Code 211.5(f) Clinical records Previously cited 3/16/19, 5/10/19 28 Pa. Code 211.12(c) Nursing services Previously cited 3/16/19, 5/10/19 28 Pa. 211.12(d)(1)(3)(5) Nursing services Previously cited 3/16/19, 5/10/19
F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Based on a review of select facility policies and procedures, closed financial record review, and staff interview, it was determined that the facility failed to ensure the required Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage was provided to one of three residents reviewed (Resident 13). Findings include: Review of the form entitled Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) states that this notice is given to make residents aware of care that no longer meets Medicare coverage requirements and they may have to pay out of pocket for the care listed. The provider must ensure that the beneficiary or their representative signs and dates the SNFABN to demonstrate that the beneficiary or their representative received the notice of possible out of pocket costs. Review of the facility's list of residents discharged from a Medicare covered Part A stay with benefit days remaining in the past six months revealed that Resident 13's last day of service was February 5, 2020, and the form NOMNC CMS- given to them explaining the out of pocket cost. There were no further documentation stating why it was not provided. Interview with Nursing Home Administrator on March 12, 2020, at 2:11 p.m. confirmed that the facility could not find documented evidence that Resident 13 or their representatives received or signed the advanced beneficiary notice. 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interview, it was determined that the facility failed to accurately complete resident assessments for two of 16 residents reviewed (Resident #3 and Resident #39). Findings include: Closed clinical record review for Resident #39 revealed a progress note dated February 14, 2020, at 4:06 p.m., that the Resident discharged to home at 3:50 p.m. Review of Resident #39's Discharge Assessment Minimum Data Set (MDS- an assessment tool

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) used to facilitate the management of care) dated February 14, 2020, revealed that the Resident was discharged to the acute care hospital. An interview with the Nursing Home Administrator (NHA) on March 11, 2020, at 1:00 p.m. confirmed that Resident 39 was discharged to home and not to the hospital. Review of Resident 3's Quarterly MDS dated [DATE], Section B Hearing, Speech and Vision revealed that the resident was understood and usually understood others. Section C Cognitive Patterns, identified that the resident was not able to be interviewed and it was coded 0 for resident is rarely/never understood. An interview with the licensed nurse, Employee E10 on March 11, 2020 at 12:40 p.m. revealed that the MDS was completed with a 0 and an interview was not attempted, which was incorrect. 28 Pa. Code 201.18(a)Management 28 Pa. Code 201.18(e)(1)(b)(1) Management Previously cited 3/16/19, 1/23/19 28 Pa Code 211.5 (f) Clinical records Previously cited 5/10/19, 3/16/19, 1/23/19 28 Pa Code 211.12 (d) (5) Nursing Services Previously cited 5/10/19, 3/16/19, 1/23/19
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility did not develop and implement a complete and person-centered care plan for one of 16 residents reviewed (Resident R3). Findings include: Review of Resident R3's clinical record revealed [DIAGNOSES REDACTED]. On January 31, 2020, a second nursing note linking to the January 30, 2020, nursing note states that the resident had a [MEDICAL CONDITION] episode. Review of Resident R3's clinical record revealed that the facility failed to develop a care plan was to address the resident's [MEDICAL CONDITION] activity. An interview with the Nursing Home Administrator on March 11, 2020, at 2:15 p.m. confirmed that the resident did not have a care plan for [MEDICAL CONDITION] activity. 28 Pa Code 211.10(d) Resident care policies 28 Pa Code 211.11(d) Resident care plan 28 Pa Code 211.5(f) Clinical records 28 Pa Code 211.12(d)(1)(5) Nursing services
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to obtain lab results for one of five residents reviewed (Resident 38). Findings include: Review of Resident 38's physician's orders [REDACTED].) and C&S (culture & sensitivity - lab test to determine which bacteria is in the urine and which antibiotics are most effective against it). Review of Resident 38's physician's orders [REDACTED]. Review of Resident 38's physician's orders [REDACTED]. Review of Resident 38's physician's orders [REDACTED]. Review of Resident 38's September 2019 progress notes, Medication Administration Record [REDACTED]. Review of Resident 38's progress notes revealed a nurse's note dated October 1, 2019 stating (telephone call) to lab to follow up with urine specimen sent. lab unable to locate results. (practitioner) made aware. New order to obtain another specimen and for urology consult. Review of Resident 38's urinalysis on October 1, 2019 revealed the resident was positive for bacteria in the urine (sign of a urinary tract infection - UTI). Review of Resident 38's progress notes revealed a nurse's note dated October 6, 2019 that the resident was positive for greater than 100,000 CFU/ml (colony-forming units per milliliter - a unit used to estimate the number of viable bacteria cells in a sample) [DIAGNOSES REDACTED] pneumoniae (type of bacteria). Review of Resident 38's physician's orders [REDACTED]. Interview with the Regional Nursing Home Administrator on March 12, 2020 at 12:20 p.m. revealed there was no documented evidence for the delay in obtaining a urine specimen and treating Resident 38's urinary tract infection. 28 Pa. Code 201.18(b)(1) Management Previously cited 3/16/19 28 Pa. Code 211.5(f) Clinical records Previously cited 3/16/19, 5/10/19 28 Pa. Code 211.12(c) Nursing services Previously cited 3/16/19, 5/10/19 28 Pa. 211.12(d)(1)(3)(5) Nursing services Previously cited 3/16/19, 5/10/19
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interview, it was determined that the facility failed to identify and provide interventions to prevent ambulation decline in a timely manner for one of five residents reviewed (Resident #27). Findings include: A review of Resident #27's clinical record revealed [DIAGNOSES REDACTED]. A review of Resident #27's Quarterly Minimum Data Set (MDS- An assessment tool used to facilitate the management of care) dated July 27, 2019, revealed that the Resident had moderate cognitive impairment. Resident #27 was able to ambulate with extensive help from one person in the room and in the corridor. A review of Resident #27's care plan initiated on September 12, 2019, revealed an intervention of a Restorative Nursing Program Ambulation (RNP). Resident 27's goal was to maintain gait. The intervention listed was to ambulate with a rolling walker with minimal assist up to 30 feet with a wheelchair to follow, and for a walk to dine program at each meal. A review of Resident #27's November 2019, RNP records revealed that the Resident did not received the ambulation program on the following dates: November 1, 2, 3, 4, 6, 8, 11, 13, 14, 16, 17, 19, 20, 21, and 22. The record was marked NA, which meant Not Applicable. Review of the same RNP form revealed that on the following dates: November 5, 9, 12, and 15, 2019, the form was blank. A review of Resident #27's clinical records revealed a Rehabilitation screen dated November 22, 2019. Resident #27 was screened by the therapist due to a nursing staff report of the Resident's increased difficulty with transfers while in the bathroom. An interview with licensed nurse Employee E4 on March 12, 2020, at 10:45 a.m., revealed that Employee E4 had been the nurse assigned to Resident #27 multiple times since she started working at the facility. Employee E4 stated that Resident #27 was unable to walk and can only pivot (body rotates about its vertical axis without traveling, may be supported by one or both feet, which swivel in place during the turn) during transfers from bed to wheelchair. An interview with nurse aide, Employee E6 on March 12, 2020, at 10:48 a.m., revealed that she was the regular morning nurse aide for Resident #27. Employee E6 stated that Resident #27 was not walking since four to five months ago. Employee E6 further stated that the Resident was only able to pivot for transfers. An interview with the Rehab Director, Employee E3 on March 12, 2020, at 11:30 a.m., revealed that Resident #27 was receiving physical therapy until they were discharged from the program on September 16, 2019. Employee E3 stated that during discharge from rehab, the resident was able to ambulate 30 feet with minimal assistance of one person with a wheelchair to follow. The resident was placed on the RNP ambulation program upon discharge from rehab. Employee E3 confirmed that the nursing staff did not notify the rehab department regarding Resident #27's decline with ambulation. Employee E3 further stated that Resident #27 was referred by nursing to rehab on November 22, 2019, due to difficulty with transferring in the bathroom for toileting. The Resident was placed on a rehab program for transferring but the assessment on November 22, 2019, revealed the Resident was not walking anymore, and therefore, no longer a candidate for ambulation program. The above was conveyed during an interview with the Nursing Home Administrator (NHA) on March 12, 2020, at 2:05 p.m. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services Previously cited 1/23/19, 3/16/19, 5/10/19 28 Pa. Code:211.5(f) Previously cited 1/23/19, 3/16/19, 5/10/19
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to provide an incontinent resident who was previously continent with care and services to attempt to restore bladder and bowel control for one of 16 residents reviewed (Resident 10). Findings include: Review of the facility policy entitled Incontinence Management Protocol, last revised on August 28, 2018, revealed a resident who is incontinent will be evaluated for appropriate intervention to regain or maintain ability to control bowel and bladder function. Review of Resident 10's admission MDS (Minimum Data Set - periodic assessment of resident needs) dated July 23, 2019, and the quarterly assessment dated [DATE], identified the resident as being always continent of both bladder and bowel. Review of Resident 10's physician's orders revealed an order dated October 28, 2019, for the resident to have an individualized bowel and bladder

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) program. Review of Resident 10's quarterly MDS dated [DATE], identified the resident as being occasionally incontinent of bladder and frequently incontinent of bowel. Review of Resident 10's Bowel & Bladder assessment dated [DATE], identified the resident as being continent of bowel and bladder. Resident 10's undated nurse aide task list revealed the resident was to have individual bowel and bladder training. Review of Resident 10's clinical record revealed no evidence that the resident was receiving an individualized bowel and bladder program. Interview with the Regional Nursing Home Administrator on March 12, 2020, at 12:20 p.m. confirmed that Resident 10's January 2020 Bowel and Bladder assessment was inaccurate in identifying the resident as continent. The interview further confirmed that there was no evidence that the facility initiated a bowel and bladder program to attempt to restore Resident 10's bowel and bladder continence. 28 Pa. Code 211.5(f) Clinical record Previously cited 3/16/19, 5/10/19 28 Pa. Code 211.10 (d) Resident care policies Previously cited 3/16/19, 5/10/19 28 Pa. Code 211.12 (c) Nursing services Previously cited 3/16/19, 5/10/19 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility's policy, clinical record review, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered pain medications for one of four residents reviewed (Resident #32). Findings include: A review of the facility's policy entitled Pain Assessment with a revision date of January 31, 2013, revealed that a continuing assessment of the pain management program will occur daily and will focus on the effectiveness of the program and the comfort level of the resident. Review of the same policy revealed that to determine the appropriate type of pain medication as ordered by the physician, staff utilize the following pain scale: one to three for mild pain, four to seven for moderate pain, and eight to 10 for severe pain. Review of Resident #32's clinical record revealed [DIAGNOSES REDACTED]. A review of Resident #32's care plan for the potential for pain related to [MEDICAL CONDITION] with a last revision date of May 24, 2019, had a goal for Resident #32 to be free from pain. The pain care plan interventions included: Monitor for pain every shift using standard zero to 10 pain scale. Administer pain medications as per physician orders [REDACTED]. Notify the physician if pain interventions are ineffective. A review of Resident #32's Quarterly Minimum Data Set (MDS- An assessment tool used to facilitate the management of care) dated November 19, 2019, revealed that Resident #32 was cognitively intact. Review of the same MDS, under Pain Management revealed that Resident #32 was frequently in pain and it was hard for the resident to sleep at night and they had limited day-to-day activities. A review of Resident #32's physician orders [REDACTED]. A review of resident #32's December 2019, Medication Administration Record [REDACTED]. Resident 32 did not have a physician's orders [REDACTED]. A review of Resident #32's physician orders [REDACTED]. A review of Resident #32's January 2020, MAR indicated [REDACTED]. A review of Resident #32's clinical record failed to reveal that staff notified the physician of the ineffectiveness of the [MEDICATION NAME] for Resident #32's frequent complaints of moderate pain. An interview with the Corporate Nursing Home Administrator on March 12, 2020, at 12:17 p.m., confirmed that the physician was not notified of the ineffectiveness of the pain medication, thus no additional pain management was provided to Resident #32. 28 Pa. Code 211.10(a)Resident care policies 28 Pa. Code 211.10(c) Resident care policies Previously cited 5/10/19, 3/16/19, 1/23/19 28 Pa. Code 211.10(d) Resident care policies Previously cited 3/16/19, 1/23/19 28 Pa. Code 211.12(d)(3) Nursing services Previously cited 3/16/19, 1/23/19 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services Previously cited 5/10/19, 3/16/19, 1/23/19
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure a medication regimen review was acted upon by a physician for one of five residents reviewed for unnecessary medications (Resident 10). Findings include: Review of Resident 10's clinical record revealed a Consultant Pharmacist's Medication Regimen Review dated November 3, 2019, recommending a gradual dose reduction (GDR - tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) of Resident 10's [MEDICATION NAME] (antipsychotic medication) 25 milligrams (mg) twice daily. Further review of Resident 10's clinical record failed to reveal that the pharmacist's recommendation was addressed by Resident 10's physician. Further review of Resident 10's Medication Regimen Reviews revealed that the pharmacist made no recommendations in December 2019. Further review of Resident 10's Medication Regimen Reviews revealed that the pharmacist again recommended a GDR on January 5, 2020, of the [MEDICATION NAME]. The physician responded on January 7, 2020 indicating that a GDR was clinically inadvisable at the time. Interview with the Regional Administrator on March 12, 2020, at 12:20 p.m. confirmed that the physician did not address Resident 10's November 3, 2019 medication regimen review until January 7, 2020. 28 Pa. Code 211.5(f) Clinical records Previously cited 3/16/19, 5/10/19 28 Pa. Code 211.12(c) Nursing services Previously cited 3/16/19, 5/10/19 28 Pa. Code 211.12(d)(3) Nursing services Previously cited 3/16/19, 5/10/19 28 Pa. Code 211.12(d)(1)(5) Nursing services Previously cited 3/16/19, 5/10/19
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to monitor side effects for [MEDICAL CONDITION] medications for one of five residents reviewed for unnecessary medications (Resident 22). Findings include: Review of the facility policy entitled [MEDICAL CONDITION] Medication Use, last revised August 29, 2018, revealed that nursing staff were to monitor residents on [MEDICAL CONDITION] medications for side effects such as tremors, slurred speech, akathisia (restlessness) [DIAGNOSES REDACTED] (involuntary muscle contractions), anxiety, distress, paranoia, bradyphrenia (slowed thinking and processing information), and tardive dyskinesia (involuntary movements of the tongue, lips, face, trunk, and extremities). Review of Resident 22's physician's orders revealed the following orders: February 4, 2020, [MEDICATION NAME] (antidepressant) 0.5 milligrams (mg) once a day January 4, 2020, [MEDICATION NAME] (antidepressant) 30 mg once a day January 3, 2020, [MEDICATION NAME] 60 mg once a day January 3, 2020, [MEDICATION NAME] XL (antidepressant) 300 mg once a day January 3, 2020, [MEDICATION NAME] (antipsychotic) 5 mg once a day Review of Resident 22's clinical record failed to reveal documented evidence that staff were monitoring the resident for side effects of these prescribed [MEDICAL CONDITION] medications. The above was confirmed with the Nursing Home Administrator during an interview on March 12, 2020, at 1:37 p.m. 28 Pa. Code 211.5(f) Clinical Records Previously cited 3/16/19, 5/10/19 28 Pa. Code 211.12(c) Nursing Services Previously cited 3/16/19, 5/10/19 28 Pa. Code 211.12(d)(3) Nursing Services Previously cited 3/16/19, 5/10/19 28 Pa. Code 211.12(d)(1)(5) Nursing Services Previously cited 3/16/19, 5/10/19
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and observation, it was determined that the facility failed to maintain complete and accurate clinical records for one of 16 residents reviewed (Resident 34). Findings include: Review of Resident 34's clinical record revealed the resident was admitted on [DATE]. Review of Resident 34's admission nursing evaluation dated February 11, 2020, revealed under the section Skin Integrity, the resident was identified as having open areas to the resident's left buttocks and sacrum. Review of Resident 34's care plan dated February 10, 2020, (the facility could not explain why the care plan date was before the resident's admission to the facility) identified the resident as having potential or actual impairment to skin integrity related to the resident's immobility and [MEDICAL CONDITION], with an

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) intervention initiated on the same date to monitor and document location, size, and treatment of [REDACTED]. areas to the left buttocks and sacrum were monitored from admission through March 12, 2020. Observation of Resident's 34's sacrum and buttocks with the Nursing Home Administrator on March 12, 2020, at 1:40 p.m. confirmed that the areas to Resident 34's sacrum and buttocks had closed on an unknown date. Interview with the Regional Nursing Home Administrator and Nursing Home Administrator on March 12, 2020, at 1:20 p.m. confirmed that there was no documentation monitoring Resident 34's open areas to the sacrum or left buttocks. 28 Pa. Code 211.5 (f) Clinical records Previously cited 3/16/19, 5/10/19 28 Pa. Code 211.12 (d)(1)(5) Nursing services Previously cited 3/16/19, 5/10/19