STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395985	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALTOONA CENTER FOR NURSING CARE	**1020 GREEN AVENUE ALTOONA, PA 16601**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** Based on clinical record reviews, observations and staff interviews, it was determined that the facility failed to provide reasonable accommodation of a resident's needs by failing to ensure that the call bell was within reach for one of 38 residents reviewed (Resident 23). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 23, dated December 23, 2019, indicated that the resident was understood and could understand, and she required the extensive assistance of two staff for bed mobility and transfers. The resident's care plan, dated September 30, 2019, included that staff were to encourage her to use her call bell for assistance. Observations of Resident 23 on March 3, 2020, at 8:32 a.m. revealed that the resident was sitting in her wheelchair on the left side of her bed and her call bell was placed on the opposite side of the bed, which was not within her reach. She was yelling out for help and wanted to be put back to bed. Interview with Licensed Practical Nurse 4 at that time revealed that Resident 23 was capable of using her call bell and it should have been placed within her reach. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that residents could make choices about aspects of their lives that were significant to them for one of 38 residents reviewed (Resident 23). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 23, dated December 23, 2019, indicated that the resident was understood and could understand, and she required the extensive assistance of two staff for bed mobility and transfers. The resident's care plan, dated September 27 and October 2, 2019, included that staff were to respect the resident's right of choice and were to anticipate the resident's needs. Observations of Resident 23 on March 3, 2020, at 8:32 a.m. and 8:49 a.m. revealed that the resident was sitting in her wheelchair on the left side of her bed and her call bell was placed on the opposite side of the bed, which was not within her reach. She was yelling out for help, indicated that she wanted to be put back to bed, she was complaining of pain, crying, and wishing she was dead, and stated that she just wanted someone to help her get back into bed. Observations on March 3, 2020, at 8:52 a.m. (20 minutes later) revealed that two staff members assisted Resident 23 into bed. Interview with Licensed Practical Nurse 4 on March 3, 2020, at 9:10 a.m. revealed that Resident 23 eats all of her meals in the dining room and as soon as she comes up from the dining room she wants to go to bed. Interviews with the Director of Nursing and Nursing Home Administrator on March 3, 2020, at 4:55 p.m. confirmed that there should be a plan in place that is based on Resident 23's choices and requests to go to bed. 28 Pa. Code 201.29(j) Resident rights. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that comprehensive Minimum Data Set assessments were completed in the required time frame for two of 38 residents reviewed (Residents 76, 89). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that for admission MDS assessments, the assessment completion date and the Care Area Assessment (CAA - the process of completing an in-depth assessment of triggered, potentially problematic care areas) completion date (Item V0200B2) were to be no later than the resident's admitted plus 13 calendar days. A comprehensive admission MDS assessment for Resident 76 revealed that the resident was admitted on [DATE]. The MDS assessment was dated as completed on December 27, 2019, which was 15 days after the admitted . A comprehensive admission MDS assessment for Resident 89 revealed that the resident was admitted on [DATE]. The MDS assessment was dated as completed on February 21, which was 14 days after the admitted . Interview with the Registered Nurse Assessment Coordinator (RNAC - a registered nurse who is responsible for the completion of MDS assessments) on March 5, 2020, at 6:05 p.m. confirmed that the above comprehensive MDS assessments were not completed in the required time frames. 28 Pa. Code 211.5(f) Clinical records.
F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assure that each resident's assessment is updated at least once every 3 months.** Based on review of the Resident Assessment Instrument Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that quarterly Minimum Data Set assessments were completed within the required time frame for one of 38 residents reviewed (Resident 10). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that quarterly assessments were to be completed no later than the Assessment Reference Date (ARD - the last day of the assessment's look-back period) plus 14 calendar days. A quarterly MDS assessment for Resident 10, with an ARD of December 10, 2019, was not signed as completed until December 27, 2019, which was 17 days after the ARD. Interview with the Registered Nurse Assessment Coordinator (RNAC - a registered nurse who is responsible for the completion of MDS assessments) on March 5, 2020, at 3:05 p.m. confirmed that the above assessment was not completed in the required time frame. 28 Pa. Code 211.5(f) Clinical records.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** Based on review of the Resident Assessment Instrument Manual and clinical records, as well as staff interviews, it was determined that the facility failed to transmit Minimum Data Set (MDS) assessments to the required electronic system, the CMS Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, within the required time frame for one of 38 residents reviewed (Resident 44). Findings include: The Long-Term Care Facility Resident

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 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (Section V0200C2 + 14 days), and all other assessments must be submitted within 14 days of the MDS Completion Date (Section Z0500B + 14 days). A quarterly MDS assessment for Resident 44 with an ARD of October 17, 2019, and signed as completed on October 29, 2019, was not transmitted/submitted until February 20, 2020. Interview with the Registered Nurse Assessment Coordinator (RNAC - a registered nurse who is responsible for the completion of MDS assessments) on March 5, 2020, at 3:05 p.m. confirmed that the quarterly MDS assessment for Resident 44 was not submitted within the required time frame. 28 Pa. Code 211.5(f) Clinical records.
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 review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate comprehensive Minimum Data Set assessments for two of 38 residents reviewed (Residents 3, 53). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, revealed that if the assessment was the first assessment since the most recent admission/entry or reentry, then Section A0310E was to be coded one (1) - Yes. Section J1700, the resident's fall history on admission/entry or re-entry, was to be completed if Section A0310E was coded one (1) - Yes. If the resident had a fall any time in the last month prior to admission/entry or reentry, then Section J1700A was to be coded one (1) - Yes. If the resident had a fracture related to a fall in the six months prior to admission/entry or re-entry, then Section J1700C was to be coded one - (1) Yes. An investigation report and nursing note for Resident 3, dated August 27, 2019, at 10:30 a.m. revealed the nurse aide was walking with the resident from her bed to the bathroom with a wheeled walker and resident lost her balance and fell over to the left side on her left shoulder and arm. An x-ray was obtained and indicated that the resident had a fractured humerus (large bone of the upper arm) and the resident was transferred to the hospital. A quarterly MDS assessment for Resident 3, dated September 10, 2019, revealed that Section A0310E was incorrectly coded zero (0) - No, indicating that this was not the resident's first MDS assessment since being readmitted . By coding Section A0310E as zero (0), the computerized MDS software did not allow Sections J1700A and J1700C to be completed to reflect that the resident had a fall and fracture in the past 30 days. Interview with Registered Nurse Assessment Coordinator 5 on March 5, 2020, at 5:40 p.m. confirmed that Resident 3's fall and fracture on August 27, 2019, was not captured on the quarterly assessment of September 10, 2019, and should have been. The RAI User's Manual, dated October 2019, revealed that Section N0410E (Anticoagulant Medications - medications that thin the blood) was to be coded with the number of days the resident received an anticoagulant medication during the seven-day assessment period. The manual's instructions included that medications were to be coded based on their pharmacological classification and not based on what they were being used for, and medications such as [MEDICATION NAME], aspirin, or diapyridamole (anti-platelet medications that prevent blood from clotting) were not to be coded as an anticoagulant medication in Section N0410E. physician's orders [REDACTED]. However, Section N0410E of a quarterly MDS assessment, dated January 22, 2020, was coded to indicate that the resident received anticoagulant medication during seven days of the assessment period (daily). Interview with Registered Nurse Assessment Coordinator 5 on March 5, 2020, at 5:40 p.m. confirmed that Section N0410E of Resident 53's quarterly assessment of January 22, 2020 was coded incorrectly. 28 Pa. Code 211.5(f) Clinical records.
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 review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a care plan was developed related to the care and services of an [MEDICAL CONDITION] for one of 38 residents reviewed (Resident 71). Findings include: The facility's policy regarding care plans, dated January 6, 2020, indicated that a resident's care plan would include interventions based on the resident's needs. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 71, dated February 3, 2020, revealed that the resident was cognitively intact, required extensive to total assistance from staff for daily care tasks, and had an ostomy (an opening made in the intestine, through the abdominal wall, that provides an alternative channel for feces to leave the body). physician's orders [REDACTED]. There was no documented evidence that a care plan related to Resident 71's [MEDICAL CONDITION] was developed. Interview with Registered Nurse Assessment Coordinator 6 (RNAC - a registered nurse who is often involved in the development of care plans) on March 5, 2020, at 5:50 p.m. confirmed that Resident 71 should have had a care plan developed related to the care of his [MEDICAL CONDITION]. 28 Pa. Code 211.11(d) Resident care plan.
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 clinical record reviews and staff interviews, it was determined that the facility failed to ensure that medication to prevent constipation was administered as ordered by the physician for one of 38 residents reviewed (Resident 72). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 72, dated February 4, 2020, indicated that the resident had moderately impaired cognition and was always incontinent of bowel. physician's orders [REDACTED].; however, the resident's Medication Administration Record [REDACTED]. The MAR for February 2020 indicated that staff did not administer MOM until February 23, 2020, at 7:38 p.m. (17 shifts). Interview with the Director of Nursing on March 4, 2020, at 1:35 p.m. confirmed that staff did not administer MOM to Resident 72 as ordered by the physician. 28 Pa. Code 211.12(d)(1) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that residents received pressure ulcer care consistent with professional standards of practice by failing to provide preventative pressure ulcer interventions as ordered by the physician for one of 38 residents reviewed (Resident 61). Findings include: A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 61, dated February 4, 2020, revealed that the resident was severely cognitively impaired, required extensive assistance from staff with bed mobility, was totally dependent for transfers, and was at risk for pressure ulcers (skin breakdown caused by pressure). physician's orders [REDACTED]. A skin assessment dated [DATE], revealed that the resident had a healing pressure area on her left ear related to oxygen tubing and a reddened open area on the coccyx (tailbone). A hospice note for Resident 61, dated March 1, 2020, revealed that the resident's heels were mushy and that a heel suspension device was ordered. Observations of Resident 61, on March 4, 2020, at 12:33 p.m. and March 5, 2020, at 10:08 a.m. revealed that the resident was in bed with a heel and calf suspension device in place, but both heels were noted to be lying directly on the bed. Interview with Registered Nurse Supervisor 3 on March 5, 2020, at 10:08 a.m. confirmed that the heel and calf suspension device was in place but Resident 61's heels were lying directly on the bed. Interview with the Director of Nursing on March 5, 2020, at 6:58 p.m. confirmed that the heel and calf suspension device should have been placed on the resident in such a way that the resident's heels would be elevated off the bed. 28 Pa. Code 211.12(d)(3)(5) Nursing services.
F 0694 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide for the safe, appropriate administration of IV fluids for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that physician's orders for the care and maintenance of intravenous catheters were obtained for one of 38 residents reviewed (Resident 75), and failed to ensure that long-term intravenous catheters were flushed according to facility policy for one

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F 0694 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) of 38 residents reviewed (Resident 6). Findings include: A nursing note for Resident 75, dated January 29, 2020, at 6:12 p.m. revealed that the resident was admitted to the facility with a midline catheter (a tube inserted in a larger vein and used for long-term intravenous medication) to the the upper arm. Physician's orders, dated Januray 29, 2020, included an order for [REDACTED]. catheter, and no documented evidence that the resident's physician was contacted to obtain orders. Resident 75's Medication Administration Record [REDACTED]. There was no documented evidence that staff flushed Resident 75's midline catheter (usually with a sterile salt and water solution) before and after the administration of [MEDICATION NAME] and [MEDICATION NAME] on these days. Interview with the Director of Nursing on March 5, 2020, at 1:44 p.m. confirmed that there were no physician's orders for the care and maintenance of Resident 75's midline catheter, and no documented evidence that the midline catheter was flushed before and after the administration of [MEDICATION NAME] or [MEDICATION NAME]. A nursing note for Resident 6, dated March 3, 2020, at 3:22 p.m. indicated that the resident had an intravenous line (midline catheter) placed in the left inner bicep. Physician's orders dated March 3, 2020, included orders for the resident to receive 1 gram of [MEDICATION NAME] HCl solution (an antibiotic) every twelve hours for seven days for urinary tract infection. The resident's MAR for March 2020 revealed that staff administered [MEDICATION NAME] HCl solution at 9:00 a.m. and 9:00 p.m. on March 4 and 5, 2020. There was no documented evidence that staff flushed Resident 6's midline catheter before and after the administration of [MEDICATION NAME] HCl on these days. Interview with the Director of Nursing on March 5, 2020, at 6:22 p.m. confirmed that there was no documented evidence that Resident 6's midline catheter was flushed before and after the administration of [MEDICATION NAME]. 28 Pa. Code 211.12(d)(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 review of the facility's policies and resident's clinical records, as well as resident and staff interviews, it was determined that the facility failed to ensure that pain management was provided for one of 38 residents reviewed (Resident 7). Findings include: The facility's pain management policy, dated January 6, 2020, indicated that staff were to effectively recognize the presence of pain for all residents, identify the characteristics of the pain and ensure that pain management was provided to the resident who required such services, along with monitoring for the effectiveness of the interventions. Documentation was to be located on the Medication Administration Record [REDACTED]. A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 7, dated July 16, 2019, indicated that the resident was cognitively intact, required extensive assistance for daily care tasks, had impaired range of motion (joint movement) of one upper extremity, a history of a fall with fracture, and [DIAGNOSES REDACTED]. The resident's arms were resting on her lap, she complained of right arm pain and was unwilling to lift the arm when asked, and crepitus (a grating sound or sensation produced by friction between bone and cartilage or the fractured parts of a bone) was noted when the right arm was assessed. The resident was place in a mechanical lift (device that uses hydraulic power to lift and move a person) and moved to bed. The right arm was elevated slightly for pain relief. The resident complained of pain that was 7 out of 10 (10 is the worst pain possible). A nursing note for Resident 7, dated July 4, 2019, at 6:32 p.m. revealed that an x-ray showed a displaced [MEDICAL CONDITION]'s right humerus (upper arm bone). At 7:36 p.m. the physician was notified about the x-ray results and a new order was received to have the resident seen by orthopedics (bone specialist) the following day. There was no documented evidence that any pain management interventions were provided for Resident 7's complaints of pain following her fall on July 4, 2019. A nursing note dated July 5, 2019, at 12:15 a.m. indicated that the registered nurse assessed Resident 7 and observed that the resident had complaints of pain in the right upper arm that was a 9. She was unable to move in bed or roll so the nurse discussed with the resident if she wished to go to the hospital and the resident expressed that desire. The resident left the facility by ambulance at 1:08 a.m. There was no documented evidence that the resident was medicated for her pain that was rated as a 9. During an interview with Resident 7 on March 4, 2020, at 2:15 p.m., the resident stated that she remembered her fall and fractured arm and remembered that it hurt like hell. Interview with the Director of Nursing on March 4, 2020, at 1:37 p.m. confirmed that no pain medication was administered to Resident 7 until 9:00 p.m. on July 4, 2019, when she received a routinely scheduled pain medication, and that she was not medicated again before leaving for the hospital. Interview with Resident 7's physican on March 4, 2020, at 3:45 p.m. revealed that Resident 7 had orders for as needed pain medication, and he would have expected the nursing staff to treat the resident's pain after her fall. 28 Pa. Code 211.12(d)(1)(5) Nursing services.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 clinical record reviews and staff interviews, it was determined that the facility failed to ensure that residents did not receive unnecessary [MEDICAL CONDITION] medication (any medication that affects brain activities associated with mental processes and behavior) for one of 38 residents reviewed (Resident 18). Findings include: A [DIAGNOSES REDACTED]. physician's orders [REDACTED]. Resident 18's Medication Administration Records (MAR's) for February 2020 revealed that staff administered 0.5 mg of [MEDICATION NAME] to the resident on February 22 at 4:30 p.m., February 23 at 9:00 a.m. and 3:00 p.m., February 24 at 8:00 a.m., February 25 at 9:00 a.m., and February 27 at 9:00 a.m., and 11:30 p.m. Nursing notes dated February 22 at 4:30 p.m., February 23 at 9:00 a.m. and 3:00 p.m., February 24 at 8:00 a.m., February 25 at 9:00 a.m., and February 27 at 9:00 a.m. and 11:30 p.m. indicated that [MEDICATION NAME] was administered for increased anxiety. The narcotic accountability log for Resident 18's [MEDICATION NAME] revealed that staff also administered [MEDICATION NAME] to the resident on February 23 at 11:00 p.m., February 24 at 6:41 p.m., and February 26 at 9:00 a.m.; however, there were no nursing notes or entries on the MAR for these dates and times. Review of Resident 18's behavior logs and tasks documentation of behaviors did not reveal that the resident had behaviors on the above dates and times, and there was no documented evidence that non-medication interventions were attempted before administering the [MEDICATION NAME]. Interview with the Director of Nursing on March 5, 2020, at 5:53 p.m. confirmed that the facility did not have a behavior documentation policy, and that [MEDICATION NAME] was administered to Resident 18 without behavior documentation and without attempting non-medication interventions first. 28 Pa. Code 211.12(d)(3)(5) Nursing services.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of manufacturer's instructions and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain a medication administration error rate of less than five percent. Findings include: Observations during medication administration on March 3, 2020, revealed that four medication administration errors were made during 51 opportunities for error, resulting in a medication administration error rate of 7.8 percent. Manufacturer's instructions for [MEDICATION NAME] nasal spray, dated January 19, 2019, indicated that before administering, the resident should blow his/her nose to clear the nostrils, close off one nostril, tilt the head forward slightly and insert the nasal applicator into the other nostril, start to breathe in through the nose while receiving the spray, breathing in gently through the nostril. These steps were to be repeated for the other nostril and then again for second dose to each nostril as prescribed. physician's orders [REDACTED].; however, the nurse did not have the resident blow his nose prior to administering the spray and did not have the resident close off the opposite nostril during administration. Interview with Licensed Practical Nurse 2 on March 3, 2020, immediately following the administation of [MEDICATION NAME], confirmed that she did not have Resident 68 blow his nose or block the opposite nostril before administering the [MEDICATION NAME]. She indicated that she was not aware that these steps were necessary prior to administering [MEDICATION NAME]. physician's orders [REDACTED]. The label on the medication bottle indicated that one tablet was 500 mg of calcium [MEDICATION NAME]. Interview with Licensed Practical Nurse 2 on March 3, 2020, at 9:44 a.m. confirmed that she administered one tablet of calcium [MEDICATION NAME] to Resident 68, and the label read that one tablet equaled 500 mg of calcium [MEDICATION NAME]. She indicated that she thought she was giving the prescibed dose of calcium [MEDICATION NAME] by administering one tablet. Interview with the Director of Nursing on March 4, 2020, at 10:30 a.m. confirmed that she was not aware that the resident should blow his/her nose and block the opposite nostril before administering [MEDICATION NAME], but

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) after reading the manufacturer's information sheet, she confirmed that this should have been done. She also confirmed that Resident 68 should have received two tablets of calcium [MEDICATION NAME] to equal the physician's prescribed dose. Manufacturer's instructions for [MEDICATION NAME] (a powdered laxative that is mixed with water), undated, indicated that the bottle top was a measuring cap and when filled to the indicated line, contained 17 grams of [MEDICATION NAME] powder. physician's orders [REDACTED]. Observations during medication administration on March 3, 2020, at 8:45 a.m. revealed that Licensed Practical Nurse 4 filled the [MEDICATION NAME] measuring cap only half way with powder and poured the two doses into a cup and added water. An interview with the Director of Nursing on March 4, 2020, at 10:27 a.m. confirmed that Licensed Practical Nurse 4 should have measured two full capfuls of [MEDICATION NAME] to equal the 34 grams ordered by the physician. 28 Pa. Code 211.12(d)(1)(5) Nursing services.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 medications were properly labeled for one of 51 residents reviewed (Resident 68), and failed to permanently affix a narcotic box to the inside of one of two medication room refrigerators (third floor). Findings include: physician's orders [REDACTED]. The label on the medication bottle indicated that one tablet of 500 mg calcium [MEDICATION NAME] was to be given to Resident 68. Interview with Licensed Practical Nurse 2 on March 3, 2020, at 9:44 a.m. confirmed that she administered one tablet of calcium [MEDICATION NAME] to Resident 68, that the label read to give one tablet of 500 mg calcium [MEDICATION NAME] twice daily, and that she did not realize that the label was incorrect and thought she was giving the prescibed dose of calcium [MEDICATION NAME] to Resident 68. Interview with the Director of Nursing on March 4, 2020, at 10:30 a.m. confirmed that the label on the calcium [MEDICATION NAME] for Resident 68 was incorrect and that he should have received two tablets to equal the prescribed dose. The facility's policy regarding the storage of controlled substances (medications with the potential to be abused), dated January 6, 2020, indicated that controlled medications requiring refrigeration were to be stored within a permanently affixed, locked box within the refrigerator. Observations in the third floor medication room refrigerator on March 5, 2020, at 5:00 p.m. revealed that the narcotic box inside the refrigerator, which held a bottle of liquid [MEDICATION NAME] (a controlled antianxiety medication) was not permanently affixed to the inside of the refrigerator. While assessing the narcotic box for security, the surveyor was easily able to pull the box off the inside wall of the refrigerator. The box had been affixed to the inside of the refrigerator with two-sided tape. Interview with Registered Nurse 1 at that time confirmed that the narcotic box was not permanently affixed to the inside of the refrigerator. Interview with the Director of Nursing on March 5, 2020, at 6:52 p.m. confirmed that the narcotic box was not permanently affixed to the inside of the refrigerator and it should have been. 28 Pa. Code 211.9(h) Pharmacy services.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 reviews and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for two of 38 residents reviewed (Residents 11, 18). Findings include: physician's orders [REDACTED]. These doses of [MEDICATION NAME] were signed out on the controlled drug accountability record (a form that accounts for each dose of a controlled drug); however, there was no documentation on the resident's Medication Administration Record [REDACTED]. Interview with the Director of Nursing on March 5, 2020, at 2:10 p.m. confirmed that staff who administered [MEDICATION NAME] to Resident 18 on February 23, 11:00 p.m. February 24, at 6:41 p.m. February 26, at 9:00, should have documented the administration on the resident's MAR. physician's orders [REDACTED]. A new physician's orders [REDACTED]. Resident 11's MAR for February 2020 revealed that both oxygen orders were initialed by staff as being completed (3 and 5 liters per minute) on all three shifts on February 21, 22, 23, 24, 25 and 26, 2020, and during the night shift on February 27, 2020. There was no documented evidence that the physician's orders [REDACTED]. Interview with the Director of Nursing on March 4, 2020, at 1:00 p.m. confirmed that the order for oxygen at 3 liters per minute should have been discontinued when the new order for oxygen at 5 liters per minute was ordered on February 21, 2020. 28 Pa. Code 211.5(f) Clinical records.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** 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 ensure that corrective plans to improve and/or correct quality deficiencies effectively addressed recurring deficiencies and ensured that the facility maintained compliance with nursing home regulations. Findings include: The facility's deficiencies and plans of correction for a State Survey and Certification (Department of Health) survey ending February 7, 2019, 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 March 5, 2020, identified repeated deficiencies related to the development of resident-centered care plans, providing quality care, providing pressure ulcer care, proper storage and labeling of medications, failure to maintain complete and accurate clinical records, and following proper infection control practices. The facility's plan of correction for a deficiency regarding the development of resident-centered care plans, cited during the survey ending February 7, 2019, 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 F656, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding the development of resident-centered care plans. The facility's plan of correction for a deficiency regarding providing quality care, cited during the survey ending February 7, 2019, 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 F684, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding providing quality care. The facility's plan of correction for a deficiency regarding ensuring that appropriate care was provided for pressure ulcer care and prevention, cited during the survey ending February 7, 2019, revealed that the facility would monitor and report concerns/findings to the Quality Improvement Committee. The results of the current survey, cited under F686, revealed that the facility's Quality Improvement Committee was ineffective in maintaining compliance with the regulation regarding pressure ulcer care and prevention. The facility's plan of correction for a deficiency regarding properly storing and labeling medications, cited during the survey ending February 7, 2019, 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 F761, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding proper storage and labeling of medications. The facility's plan of correction for a deficiency regarding clinical records that were not complete and accurate, cited during the survey ending February 7, 2019, indicated that audits of documentation would be completed and the results of the audits would be presented at the QAPI committee. The results of the current survey, cited under F842, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding complete and accurately documented clinical records. The facility's plan of correction for a deficiency regarding following infection control practices, cited during the surveys ending February 7, 2019, 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 F880, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding following infection control practices. Refer to F656,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395985	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALTOONA CENTER FOR NURSING CARE	**1020 GREEN AVENUE ALTOONA, PA 16601**

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 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) F684, F686, F761, F842, F880. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper infection control practices were followed while providing medications for two of 51 residents reviewed (Residents 19, 68). Findings include: The facility's policy regarding administering oral medications, dated January 5, 2020, indicated that staff were not to touch the medications with their hands. Observations during medication administration on March 3, 2020, at 8:45 a.m. revealed that Licensed Practical Nurse 4 prepared to administer medications to Resident 19 and obtained the medication from a blister card. The nurse touched a medication tablet with her bare hands, placed it in a souffle cup, and administered it to the resident. Interview with Licensed Practical Nurse 4 on March 3, 2020, at 8:48 a.m. revealed that she should not have touched Resident 19's medication with her bare hands. Interview with the Director of Nursing on March 4, 2020, at 10:30 a.m. confirmed that staff were not to touch residents' medications with their bare hands. The facility's policy regarding hand washing, dated January 6, 2020, indicated that all personnel were required to wash their hands after each direct or indirect resident contact, whether or not gloves have been worn. Observations during medication administration on March 3, 2020, at 8:50 a.m. revealed that without washing her hands first, Licensed Practical Nurse 2 put a glove on her right hand, administered one spray of [MEDICATION NAME] (to treat allergies [REDACTED]. Interview with Licensed Practical Nurse 2 at that time confirmed that she did not wash her hands before or after applying the glove and administering the nasal spray and she should have. Interview with the Director of Nursing on March 4, 2020, at 10:30 a.m. confirmed that Licensed Practical Nurse 2 should have washed her hands before and after using gloves and administering medication. 28 Pa. Code 211.12(d)(1)(5) Nursing services.