STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395687	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
YORK NURSING AND REHABILITATION CENTER	7101 OLD YORK ROAD OAK LANE, PA 19126

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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 the Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual and resident and staff interviews, it was determined that the facility failed to ensure that Minimum Data Set Assessments accurately reflected the status for one of 36 residents reviewed (Residents R99). Findings include: The RAI User's Manual, Section N0410, entitled Medications Received, directs facility staff to record by drug classification the number of days that anticoagulants, such as [MEDICATION NAME] or [MEDICATION NAME], are received. Section N0410, of Resident R99's Quarterly MDS (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated 01/24/20, indicated that Resident R99 received an anti-coagulant medication on seven of the seven days of the assessment period. Review of Resident R99's January 2020 Medication Administration Record [REDACTED]. The facility failed to ensure that the MDS assessment accurately reflected anticoagulant use. 28 Pa. Code 211.5 (f)(g) Clinical records 28 Pa. Code 211.12 (d)(1)(5) Nursing services 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 observations and resident and staff interviews, it was determined that the facility failed to follow or clarify physician orders [REDACTED]. Findings include: Review of facility policy, Fingerstick Blood Glucose Testing - WITH Sliding Scale Insulin Coverage, dated 2009, revealed that staff would perform a finger stick blood glucose (testing blood sugar levels) as ordered by the physician, and treat the elevated blood sugar level with sliding scale (medication administered per parameters as specified and ordered by the physician) insulin (injectable medication to treat elevated blood sugar levels) as ordered by the physician. Review of the clinical record for Resident R153 revealed the resident had [DIAGNOSES REDACTED]. Review of a physician's orders [REDACTED]. The physician's orders [REDACTED]. Review of the Medication Administration Record (MAR) for Resident R153 for February 2020, revealed the following documented blood sugar levels greater than 250 mg/dL: February 23, 2020, blood sugar 374 mg/dL at 4:00 p.m.; February 25, 2020, blood sugar 280 mg/dL at 4:00 p.m.; and blood sugar 276 at 4:00 p.m. on February 26, 2020. Further review of the MAR and clinical record revealed no documentation that facility staff notified resident R153's physician of the elevated blood sugar levels on February 23, 25, and 26, 2020, as ordered by the physician. Further review of the physician's orders [REDACTED]. Further review of the clinical record revealed no documentation of a physician's orders [REDACTED]. Interview with the Assistant Director of Nursing on March 5, 2020, at approximately 11:53 a.m. confirmed there was no documentation that facility staff notified the physician of Resident R153's elevated blood sugar levels at 4:00 p.m. on February 23, 25, and 26, 2020; and no documentation that a sliding scale insulin order was obtained and clarified by staff. Review of Resident 91's clinical record revealed the resident was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. Review of the resident's clinical record revealed an eye specialist consult dated October 17, 2019, revealed the optometrist recommended artificial tears one drop in both eyes four times a days with no discontinue date. Further, review of the resident's clinical record revealed no documented evidence that the resident's attending physician was communicated the recommendations of the eye specialist and that an order was obtained for artificial tears eye drops as recommended by the optometrist. Interview on March 4, 2020, at 1:30 p.m. with licensed nursing staff, Employee E3, where it was confirmed that there was no documented evidence the resident received the eye drops as recommended by the optometrist. The facility failed to ensure that residents received treatment and care to ensure the highest possible level of functioning and well-being. 28 Pa. Code 211.5(f)Clinical records 28 Pa. Code 211.10(c)Resident care policies 28 Pa. Code 211.12 (d)(1)(5) Nursing services 28 Pa. Code 211.12 (d)(1)(5) Nursing services
F 0694 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 review, review of professional literature, review of facility policies and interviews with staff, it was determined that the facility failed to assess a PICC line in accordance with professional practice standards for one of 36 residents reviewed (Resident R425). Findings include: Review of the undated facility policy, Catheter Insertion and Care undated, revealed that staff are to consult the state nurse practice act for RN(Register Nurse)/LPN (Licensed Practical Nurse) scope of practice and functions as general guidelines. According to the standards of nursing practice guidelines in the Journal of the American Nurse's Association, dated November 2013, complications of a PICC line (Peripherally Inserted Central Catheter Line, type of IV used for long term use) includes, but is not limited to catheter-tip migration (assessed by external length of the catheter-amount of catheter tubing that is visible outside of the vein moves from original insertion and may cause medical complications). Clinical record review for Resident R425 revealed that the resident was admitted on [DATE] with a right upper arm PICC Line to be used for IV antibiotic therapy. Further review of the PICC line insertion information from the hospital records revealed no documentation of the external catheter length that the facility could use for comparison for monitoring for catheter migration. Further clinical record review revealed that the external length of the catheter was not documented until March 3, 2020, when a late note dated March 1, 2020, was entered which listed the external length as -0.6 cm. Continued clinical record review for Resident R425 revealed that on March 5, 2020, a late note was entered for February 29, 2020, which listed the external catheter length as 10 cm. An interview with the Director of Nursing on March 5, 2020, at approximately 12:25 p.m. confirmed that there was no external catheter length for the PICC Line on the right upper arm of Resident R425 documented on the paperwork from the hospital upon transfer. He also confirmed that the staff measurements that were listed on the late entry progress notes entered on March 3 and March 5, 2020 were not taken correctly as his direct observation revealed that there was a zero external catheter length on the PICC line of Resident R425. The facility failed to assess a PICC line catheter in accordance with professional practice standards. 42 CFR 483.25(h) [MEDICATION NAME] Fluids 28 Pa Code 211.5(f) Clinical records. 28 Pa Code 211.12(d)(5) Nursing services.
F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and interviews with residents and staff, it was determined that the facility failed to adequately monitor, assess, and provide the necessary and timely behavioral health care and services for prevention and treatment of [REDACTED]. Findings include: Interview with Resident R72 on March 2, 2020, at approximately 11:15 a.m.

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 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) revealed the resident was awake, alert and able to answer questions appropriately. During interview and conversation with the resident, Resident R72 told surveyor of possible discharge to Florida later that week, and that the resident was excited with the prospect of being able to be discharged . Review of the clinical record for Resident R78 revealed the resident was admitted to the facility from a 21 day substance abuse residential (inpatient) rehabilitation treatment program on October 3, 2019, with [DIAGNOSES REDACTED]. Review of a social service admission summary progress note, dated October 4, 2019, at 5:05 p.m. revealed Resident R72's BIMS (Brief Interview for Mental Status, a brief screening tool that aids in detecting cognitive impairment. Scores from the BIMS assessment suggest the following distributions: 13-15 cognitively intact; 8-12 moderately impaired; 0-7 severe impairment) score of 15, indicating the resident was cognitively intact. Review of the plan of care for Resident R72, dated initiated October 4, 2019, revealed that one of Resident R72's goals was to be discharged to the community after the resident's stay at the facility. Review of a social service progress note dated October 7, 2019, at 3:32 p.m. revealed that the social worker referred Resident R72 to be seen by psychology for past medical history of [REDACTED]. Review of a certified registered nurse practitioner (CRNP) psychiatric comprehensive consult progress note dated October 15, 2019, at 7:27 p.m. revealed the CRNP was, asked to evaluate (Resident R72's) mood and behavior, and indicated that for the resident's past or current substance abuse history, the CRNP documented none for drugs. Further review of the CRNP psychiatric comprehensive consult progress note revealed no documentation that Resident R72 was evaluated by the psychiatric CRNP for past medical history of [REDACTED]. Review of a psychology consultation report dated October 31, 2019, revealed Resident R72 was introduced to cocaine later in life, that the resident was in the facility, pending residential placement, and that the psychologist would follow up with supportive 1:1 (one-to-one) psychology treatment to, help facilitate recovery efforts. Review of a social service progress note dated December 27, 2019, at 8:26 a.m. revealed that the social worker referred Resident R72 to be seen by psychology related to loss of the resident's roommate. Review of a psychology consultation report dated January 2, 2020, revealed Resident R72 was previously seen by that provider on October 31, 2019, that the resident was seen due to recent loss of roommate, that Resident R72 was not content living at the facility, and that the resident wanted to transfer to another nursing facility. Further review of the clinical record on March 3, 2020, revealed no documentation that Resident R72 had ongoing assessment, monitoring, support and treatment for [REDACTED]. Interview with the Nursing Home Administrator and Director of Nursing on March 5, 2020, at 8:45 a.m. confirmed there was no documentation of ongoing assessment, treatment and psychiatric support for resident's drug rehabilitation. The facility failed to provide the necessary behavioral health care and services to attain or maintain Resident R72's highest practicable physical and psychosocial well-being. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.21(b) Use of outside resources 28 Pa. Code 201.29(j) Resident rights 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(c)(d)(3) Nursing services
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on review of facility documentation, observations, and resident and staff interviews, it was determined that the facility failed to provide food and drink that was palatable and served at the proper temperature for two of 36 residents reviewed (Residents R91 and R177). Findings include: Interview with Resident R91 on March 2, 2020, at approximately 10:30 a.m. revealed that the resident felt that the food was undercooked and cold when served. Interview with Resident R177 on March 2, 2020, at approximately 10:40 a.m. revealed that the resident felt that food served at all three meals each day was cold. Observations on March 4, 2020, at approximately 12:45 p.m. with Employee E4, Food Service Director (FSD), during a test tray evaluation done in the two south dining room revealed that the temperature of the BBQ Chicken was 120 degrees, the diced potatoes were 111 degrees, the apple juice was 56 degrees and the banana pudding was 53.6 degrees. A review of the facilities Test Tray Evaluation Form revealed that the acceptable point of service temperature for hot food was listed as greater than or equal to 125 degrees and cold food was listed as less than or equal to 50 degrees. All food items listed above were outside the acceptable point of service temperatures. An interview with the FSD on March 4, 2020, at approximately 12:55 p.m. confirmed that the chicken and potatoes were below the acceptable temperature and therefore too cold to be palatable and the apple juice and banana pudding was above the acceptable temperature and was too warm to be palatable. The facility failed to provide food and drink that was palatable and at a safe temperature that was appetizing to the residents. CFR 483.60(d)(2) Food and drink 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.29(j) Resident rights 28 Pa. Code 211.6(f) Dietary services
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, and resident interview, it was determined that the facility failed to ensure that residents were provided with food items in accordance with their preferences for one of 36 residents reviewed (Resident R207). Findings include: Review of Resident R207's clinical record revealed the resident was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. Review of a registered dietician note dated February 18, 2020, revealed the resident requested to speak with the dietician regarding his sodium intake and to update his food preferences. The resident wanted a garden side salad with hard boiled eggs for lunch daily. During the initial tour of the facility on March 2, 2020, at 10:05 a.m. Resident R207 stated that he has liver disease and he wanted to be on a low sodium diet. The resident stated that the facility served him meals that were not low in sodium to include gravy, hot dogs, and cheese steaks. Observation on March 2, 2020, of the lunch meal service revealed that Resident R207 did not want to eat his lunch because his meal included beef stew, buttered noodle, and a biscuit and a margarine and not the garden side salad with hard boiled eggs as preferred. The facility failed to ensure that residents were provided with food items in accordance with their preferences. 28 Pa. Code 211.29 (j) Resident rights.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with staff, it was determined that the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. Findings include: An initial tour of the Food Service Department conducted on [DATE], at 9:30 a.m. with Employee E4, Food Service Director (FSD), revealed the following: Observation in the outside loading dock and receiving area revealed two stacks of wooden pallets piled five to six pallets high up against the HVAC (air conditoning) system just outside the receiving dock door. Observations in the dry storage areas revealed an accumulation of dirt and dust on the floor under the shelves. There was a four-ounce portion cup left a bulk container Labeled Korean Rice. Further observation in the dry storage areas revealed dented cans sitting on an unlabeled shelf intermingled with other food supplies. There was a paper sack labeled breadcrumbs which was unsealed and leaking its contents into the cardboard master case. Further observation of the emergency food rack, which was just outside the dry storage area, revealed a case of thickened juice which had expired in [DATE]. Observations in the kitchen revealed an accumulation of dark, blackish dust and dirt in the corners where the walls meet the floor, and near the coffee machine the baseboard material was lose and coming off the wall. Further observation of the window above the food preparation area revealed a thick accumulation of dust on the walls and window ledge, and visible gaps between the window frame and the air conditioning unit in the window which were large enough for pests to enter the kitchen from outside. Observations in the walk-in freezer revealed an open cardboard box of egg patties with the inner plastic liner left open to the air. Observations in the walk-in cooler revealed a tray of ground beef thawing on top of a box of boneless beef inside round roasts which are cooked to a lower final internal temperature than the ground beef. Observations in the kitchen revealed a black floor fan near the hot food production area which had an accumulation of dark, blackish dust and dirt on the fan blades and the fan guard and the fan was on and blowing air into the food preparation area. Further observation in the kitchen revealed two convection ovens with a heavy build-up of blackish baked on food residue on the inside surfaces of the oven, and a cooktop with burned on food spatters on the cooking surface and the control knobs on the front of the stove had a heavy build-up of blackish grease and grime. Continued observation revealed bulk food bins containing flour, rice and sugar had broken lids which did not provide a tight cover to prevent contamination and pests.

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) Observation of the floor between the kitchen and dish room was missing a transition strip between the quarry tile and linoleum flooring revealing broken uneven tiles. Observation of the HVAC units in the kitchen revealed a heavy build-up of dust and dirt on the electric lines, boxes and other surfaces. Observation of the reach-in refrigeration units in the kitchen revealed an accumulation of dust and dirt on the louvers above the units. These observations were confirmed during an interview with the FSD conducted on [DATE], at approximately 10:00 a.m. The dining observation conducted on [DATE], at 11:50 a.m. on the first floor main dining room, revealed that the dietary aide set up the steamtable including uncovering the pans, placing the pans into the steam table and placing the serving utensils into the pans of food all without washing his hands or putting on gloves. These dining observations were reviewed with the Nursing Home Administrator and Director of Nursing on [DATE], at approximately 2:00 p.m. The facility failed to store, prepare and serve food in accordance with professional standards for food service safety. 42 CFR 483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. 28 PA Code: 201.14(a) Responsibility of licensee. 28 PA Code: 201.18(e)(1) Management. 28 Pa. Code 201.18(b)(3) Management