STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396088	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLE WINDS HEALTHCARE AND REHABILITATION, LLC	4112 SPRING HILL ROAD PORTAGE, PA 15946

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
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.** Based on review of policies, information provided by the facility, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for one of five residents reviewed (Resident 3) who received oxygen. Findings include: The facility's policy regarding care plans, dated March 5, 2019, revealed that all residents were to have individualized care plans that outlined the specific areas of care that each resident required. When any resident was admitted to the facility, the admitting nurse was to implement care plans that were specific to the resident, and the registered nurse was to update each resident's care plan upon receiving new orders that changed the prior plan. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated February 25, 2020, revealed that the resident was understood and could understand, and required extensive assistance from staff for daily care tasks. A nursing note for Resident 3, dated February 22, 2020, at 2:02 p.m. revealed that the resident's oxygen saturation level decreased to 86 percent (normal readings usually range from 95 to 100 percent) that a.m. The resident denied any complaint of dyspnea (difficulty breathing). The note indicated that the resident previously wore oxygen, oxygen was placed at two liters per minute, and the resident's oxygen saturation was now stable at 95 percent with oxygen at two liters per minute. A nursing note on February 22, 2020, at 4:38 p.m. revealed that the resident was assessed due to a low oxygen saturation level on the previous shift, and she was resting in bed, was awake and alert, and her oxygen saturation level was 94 percent on oxygen at three liters per minute. As of March 4, 2020, there was no documented evidence that a care plan was developed related to Resident 3's oxygen use. Observations of Resident 3 on March 4, 2020, at 8:04 a.m. revealed that the resident was sitting in her room with oxygen in place via nasal cannula (tubes that deliver oxygen into the nostrils) at 2 liters per minute. Interview with the Director of Nursing on March 4, 2020, at 11:45 a.m. confirmed that a care plan was not developed regarding Resident 3's oxygen use. 28 Pa. Code 211.11(d) Resident care plan.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **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 respiratory care was provided in accordance with professional standards of practice, by failing to obtain physician's orders for the administration of oxygen for one of five residents reviewed (Resident 3), and failing to ensure that respiratory treatments were provided as ordered by the physician for one of five residents reviewed (Resident 2). Findings include: The facility's policy regarding care plans, dated March 5, 2019, revealed that oxygen was to be administered in accordance with the physician's order, and staff were to check the physician's order. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated February 25, 2020, revealed that the resident was understood and could understand, and required extensive assistance from staff for daily care tasks. A nursing note for Resident 3, dated February 22, 2020, at 2:02 p.m. revealed that the resident's oxygen saturation level decreased to 86 percent (normal readings usually range from 95 to 100 percent) that a.m. The resident denied any complaint of dyspnea (difficulty breathing). The note indicated that the resident previously wore oxygen, oxygen was placed at two liters per minute, and the resident's oxygen saturation was now stable at 95 percent with oxygen at two liters per minute. A nursing note on February 22, 2020, at 4:38 p.m. revealed that the resident was assessed due to a low oxygen saturation level on the previous shift, and she was resting in bed, was awake and alert, and her oxygen saturation level was 94 percent on oxygen at three liters per minute. As of March 4, 2020, there was no documented evidence that a physician's order was obtained for Resident 3's oxygen use. Observations of Resident 3 on March 4, 2020, at 8:04 a.m. revealed that the resident was sitting in her room with oxygen in place via nasal cannula (tubes that deliver oxygen into the nostrils) at 2 liters per minute. Interview with the Director of Nursing on March 4, 2020, at 11:45 a.m. confirmed that there were no physician's orders obtained for Resident 3's oxygen use, and an order should have been obtained when the resident initially received oxygen. A [DIAGNOSES REDACTED]. Interview with the Director of Nursing on March 4, 2020, at 11:50 a.m. confirmed that incentive spirometry was not provided as ordered by the physician for Resident. 28 Pa. Code 211.12(d)(3)(5) Nursing services.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **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 were free from significant medication errors by failing to provide respiratory medications as ordered by the physician for one of five residents reviewed (Resident 2). Findings include: A [DIAGNOSES REDACTED]. Interview with the Director of Nursing on March 4, 2020, at 11:50 a.m. confirmed that [MEDICATION NAME] treatments were not provided as ordered by the physician for Resident 2. 28 Pa. Code 211.12(d)(1)(5) Nursing services
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** 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 hand hygiene procedures were followed by staff involved in direct resident contact for one of five residents reviewed (Resident 1). Findings include: The facility's policy regarding hand washing, dated March 5, 2019, indicated that hands were to be washed before applying and after removing gloves, and when visibly soiled. A comprehensive significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated February 12, 2020, indicated that the resident was always incontinent of urine and bowel and required the extensive assistance of two staff for hygeine. Observations of Resident 1 on March 4, 2020, at 8:30 a.m. revealed that Nurse Aides 1 and 2 assisted the resident to use the toilet. Afterward, Nurse Aide 1 performed hygeine care and her glove was visibly soiled. The nurse aide wiped her glove off with a cleansing wipe and then proceeded to apply protective cream to the resident's buttocks with the same glove on. She then removed her gloves, and without washing her hands she applied a clean incontinent brief and the resident's clothing. Interview with Nurse Aide 1 on March 4, 2020, at 8:46 a.m. confirmed that she should have removed her gloves and washed her hands after providing hygiene care to Resident 1 and before applying the ointment. Interview with the Assistant Director of Nursing on March 4, 2020, at 11:56 a.m. confirmed that after providing hygeine care, staff were to remove their gloves and wash their hands before providing further care. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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.