STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395080	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PHOEBE ALLENTOWN HEALTH CARE CENTER	**1925 TURNER STREET ALLENTOWN, PA 18104**

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, facility documentation review and staff interview, it was determined that the facility failed to ensure that each resident remained free from physical abuse for one of 35 sampled residents. This deficiency is cited as past non-compliance. (Resident 22) Findings include: Review of the facility policy entitled Abuse Policy-Prevention, Reporting, Investigation, dated April 2, 2019, indicated that all residents have the right to be free from abuse. Abuse was defined as, but not limited to, intimidation or punishment with resulting physical harm, pain, or mental anguish. Clinical record review revealed that Resident 22 was admitted to the facility on [DATE], and had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE], reflected that the resident was cognitively impaired, displayed feelings of being tired or little energy, displayed no problematic behavioral symptoms, and required extensive staff assistance for transferring between surfaces and for moving between locations. Nursing documentation dated February 7, 2020, at 11:49 p.m., noted that an incident occurred on that date at 10:45 p.m. in which the resident had displayed combative behavioral symptoms while being taken to his room for care and leaped out of his chair onto the floor. The nurse's note also indicated that the, Resident stated the aides were grabbing him and forcing him into his room where he didn't want to go. They were also laughing at him and ignoring him. Review of the facility's investigation submitted as complete on February 13, 2020, revealed that staff did try and force the resident to go to bed when he did not want to. The actions of physical abuse included one nurse aide hitting the resident and one another nurse aide using force in handling the resident. The facility determined that the findings substantiated resident abuse involving physical and mental anguish of Resident 22. During an interview on March 13, 2020, at 9:34 a.m., the Nursing Home Administrator confirmed that staff had abused the resident on February 7, 2020. This deficiency is cited as past non-compliance. Information submitted by the facility to the Department included the following corrective actions in response to the abuse by staff to Resident 22: involved staff members were terminated, current facility staff were in-serviced on resident abuse identification, prevention, and reporting, resident rights, and stress management, and behavioral health interventions were provided to the resident. The facility's implementation of the plan of correction began February 13, 2020, and was completed March 6, 2020. Documentation supported that the plan was being monitored for implementation by the Nursing Home Administrator. 28 Pa. Code 201.29(j) Resident rights. 28 Pa. Code 211.12(d)(1)(5) Nursing services.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide interventions, including supervision, to ensure safety and prevent aspiration for one of 35 sampled residents. (Resident 17) Findings include: Clinical record review revealed that Resident 17 had [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident had memory problems and required supervision for eating. A speech therapy discharge summary dated September 3, 2019, in addition to the current care plan included that the resident was to remain fully upright for meals and for 30 minutes after meals and was to consume small half-teaspoon bites with small sips of fluids was not to talk during the meal. In addition, staff was to ensure that the resident alternated solids and liquids during the meal and was to be closely supervised. There was also a physician's orders [REDACTED]. Observation of lunch on March 10, 2020, from 12:19 p.m. through 12:40 p.m., revealed that the resident was served a grilled cheese sandwich, two Danishes and a drink, while in bed with the head of the bed at approximately 30 degrees. Staff left the resident unsupervised in the room with her curtain pulled and not visible from the corridor. The resident was observed eating regular sized spoonful bites, speaking while eating, and not alternating solids and liquids while lying in the bed. Observation of breakfast on March 11, 2020, from 9:17 a.m. through 9:50 a.m., revealed that the resident was eating a pancake, Danish, and drink while in bed with the head of the bed at approximately 30 degrees. The resident was unsupervised with the privacy curtain pulled and was not visible from the corridor. The resident was again observed eating regular sized spoonful bites and not alternating liquids and solids. In an interview on March 11, 2020, NA1, who was assigned to Resident 17, was unaware of special feeding instructions which included supervision of the resident. CFR 483.25(d) Accidents Previously cited 4/5/19 28 Pa. Code 211.12(d)(1)(3)(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 clinical record review and staff interview, it was determined that the facility failed to provide physician ordered behavioral health interventions for one of nine sampled residents with behavioral and/or mood symptoms. (Resident 52) Findings include: Clinical record review revealed that Resident 52 had [DIAGNOSES REDACTED]. The physician ordered that the resident was to receive an anti-anxiety medication daily. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was having verbal behavioral symptoms directed at others. The MDS assessment dated [DATE], noted that the resident displayed mood symptoms, including little interest or pleasure in doing things. There was a physician order [REDACTED]. In addition, the current plan of care indicated that the resident had mood symptoms related to admission and his disease process and interventions included behavioral consults (such as psychiatric) as needed. There was a lack of documentation to support that the resident was offered a psychiatric consultation as ordered by the physician. In an interview on March 13, 2020, at 1:00 p.m., the Nursing Home Administrator confirmed that the psychiatric consultation had not been done. 28 Pa. Code 211.12(d)(3)(5) Nursing services.
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.**

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 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, it was determined that the facility failed to ensure that an as needed anti-anxiety medication was limited to a duration of 14 daysfor one of 35 sampled residents. (Resident 52) Findings include: Clinical record review revealed that Resident 52 had [DIAGNOSES REDACTED]. Review of the Medication Administration Record [REDACTED]. There was a lack of documentation that the physician provided a rationale to extend the duration for the continued use of the as needed [MEDICAL CONDITION] medication. 28 Pa. Code 211.12(d)(1)(5) Nursing 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 review, observation, resident interview, and staff interview, it was determined that the facility failed to provide food according to resident preferences for one of 35 sampled residents. (Resident 52) Findings include: Clinical record review revealed that Resident 52 had [DIAGNOSES REDACTED]. On December 12, 2019, the physician ordered the resident to receive a regular dysphagia advanced texture diet with thin liquids. The Minimum Data Set (MDS) assessment, dated January 15, 2020, indicated that the resident was receiving hospice services and required staff supervision with eating. Observation of lunch on March 10, 2020, at 12:02 p.m., revealed that Resident 52 was served two bowls of cereal with milk, ice cream, and orange drink. The meal ticket on the resident's tray indicated that the resident was to be provided with menu items including beef rice soup, ground hot roast beef on wheat, power cheese potatoes, banana pudding, and power chocolate milk. The resident stated he would like to have the banana pudding and chocolate milk and might like the beef rice soup. In an interview on March 10, 2020, at 12:10 p.m., NA2 stated that she had not offered the resident any of the planned menu items. 28 Pa. Code 201.29(j) Resident rights. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.