STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396064	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARGARET E. MOUL HOME	**2050 BARLEY ROAD YORK, PA 17404**

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 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Based on review of select facility documentation and staff interview, it was determined that the facility failed to provide evidence that the required notices to the resident or the resident's representative following the end of their Medicare coverage were provided for three of three residents reviewed who remained in the facility for long-term care (Residents 58, 75 and 76). Findings include: Review of a Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form, partially completed by the facility indicated that Resident 58 would no longer receive Medicare Part A Coverage starting December 24, 2019, included information regarding potential costs, and did not contain any signatures or dating of acknowledgement of receipt from resident or resident representative. Review of an Advanced Beneficiary Notice of Non-coverage regarding Resident 58 also revealed a partially completed form which indicated that Medicare Part a services would end on December 23, 2019, and did not contain any signatures or dating of acknowledgement of receipt from resident or resident representative. Review of Resident 58's progress notes revealed a note dated for December 19, 2019, that a Letter of Notice of Medicare Non-coverage and (SNFABN) was given to (Resident) and mailed to her sister . (sister's name) today. Last date of Medicare 12-23-19. Review of a Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form, partially completed by the facility indicated that Resident 75 would no longer receive Medicare Part A Coverage starting September 27, 2019, included information regarding potential costs, and did not contain any signatures or dating of acknowledgement of receipt from resident or resident representative. Review of an Advanced Beneficiary Notice of Non-coverage regarding Resident 75 also revealed a partially completed form which indicated that Medicare Part a services would end on September 26, 2019, and did not contain any signatures or dating of acknowledgement of receipt from resident or resident representative. Further review of this form revealed a handwritten note Letter mailed to (name of resident's representative) 9/24/19 also called (name of resident's representative) to notify by phone with a dated signature of 9/24/19. Review of a Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form, partially completed by the facility indicated that Resident 76 would no longer receive Medicare Part A Coverage starting February 8, 2020, included information regarding potential costs, and did not review any signatures or dating of acknowledgement of receipt from resident or resident representative. Review of an Advanced Beneficiary Notice of Non-coverage regarding Resident 76 also revealed a partially completed form which indicated that Medicare Part a services would end on February 7, 2020, and did not reveal any signatures or dating of acknowledgement of receipt from resident or resident representative. Review of Resident 76's progress notes revealed a note dated for February 5, 2020, which revealed (resident's name) was given his cut letters for Medicare. His Medicare will end on 2720. Facility did not provide any additional information to confirm that Residents 58, 75 and 76 or their representatives were explained the information contained in the forms regarding their discontinued services. During an interview with Nursing Home Administrator (NHA) on March 5, 2020, at approximately 11:50 AM the NHA revealed the expectation that the forms would be completed to include information regarding resident/resident representative acknowledgement of the information. . 28 Pa. Code 201.18(e)(1) Management.
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 clinical record review and staff interview, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for one of 20 residents reviewed (Resident 71). Findings include: Review of Resident 71's clinical record revealed [DIAGNOSES REDACTED]. Review of Resident 71's annual MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs), dated November 22, 2019 and modification of quarterly MDS, dated [DATE], both revealed that in section I, Resident 71 was coded as having pneumonia. Review of Resident 71's clinical record failed to reveal any evidence that Resident 71 was treated for [REDACTED]. During an interview with Licensed Practical Nurse (LPN) 1 on March 5, 2020, at 9:22 AM she stated that Resident 71 has not had any infections recently and it has been a while since she had pneumonia. On March 5, 2020, at 10:36 AM the Registered Nurse Assessment Coordinator (RNAC) stated that both of the MDS's were marked in error for pneumonia and stated that pneumonia should not have been coded. On March 5, 2020, at 11:46 AM the Director of Nursing stated that both of the MDS's have been corrected. 28 Pa. Code 211.5(f) Clinical records.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **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 review and revise the care plan for one of 20 residents reviewed (Resident 26). Findings include: Review of the clinical record for Resident 26 revealed [DIAGNOSES REDACTED]. On February 25, 2020, an ulcer wound sheet was initiated by Registered Nurse (RN) 2, identifying the area on the right ischial as a stage 1 pressure ulcer. The treatment to the area was documented as [MEDICATION NAME] (a barrier cream designed to heal cuts and wounds) with care. Another ulcer skin sheet dated March 3, 2020 also indicated that the treatment was [MEDICATION NAME] with care. Review of the current facility policy titled, skin care treatment protocol guideline states that treatment options for a stage 1 pressure ulcer is skin prep per nursing judgment. Review of the care plan and resident care profile (reference for nurse aids) revealed that [MEDICATION NAME] application was not on the care plan or care profile. During an interview with the Director of Nursing on March 5, 2020 at 11:43 AM she confirmed that the [MEDICATION NAME] cream should have been on the care profile. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough food/fluids to maintain a resident's health.** **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 maintain an acceptable parameter of nutritional status for one of 17 residents reviewed receiving tube feedings (Resident 65). Findings include: Review of the clinical record for Resident 65 revealed [DIAGNOSES REDACTED]. Review of the current physician orders [REDACTED]. Review of the nutrition assessment performed by the dietician on March 3, 2020, revealed that the resident needs 1200 calories (Cal) and with the current tube feed order she is receiving 1137. Review of the product information sheet for [MEDICATION NAME] 1.2 revealed that to meet 100% of RDI (recommended daily intake) (the quantity of a particular nutrient which should be consumed daily in order to maintain good health) for 24 essential vitamins and minerals in 1200 Cal (1 liter). During an interview with the Dietician on March 5, 2020 at 10:42 AM she confirmed that the 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 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) needs 1200 Cal and is receiving 1137. She also confirmed that there were days that the resident received less than the ordered amount of tube feed. During an interview with the Nursing Home Administrator and Director of Nursing on March 5, 2020 at 11:40 PM they acknowledged the need for the essential vitamins and minerals. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of employee personnel files, clinical records and select facility policy and staff interview it was determined that the facility failed to ensure that a licensed nurse demonstrated competency in the necessary skills and resident care tasks to meet resident needs as evidenced by one licensed nurse (Employee 1) out of two files reviewed. Findings include: Review of the clinical record for Resident 26 revealed [DIAGNOSES REDACTED]. Review of current faciltiy policy titled Skin care treatment protocol guideline, defines a pressure injury (ulcer) as localized damage to the skin and underlying tissue usually over a bony prominence. The injury can present as intact skin or an open ulcer. The injury occurs as a result of intense or prolonged pressure. The policy defines a stage 1 pressure injury as non blanchable (the skin does not turn white when touched with a finger) [DIAGNOSES REDACTED] (redness) of intact skin. Further review of the clinical record for Resident 26 revealed a skin sheet dated February 16, 2020 that identified an reddened area 2 cm x 0.8 cm on the right ischial (the bony protrusion which takes the body ' s weight during sitting). On February 25, 2020 an ulcer wound sheet was initiated by Registered Nurse (RN) 2, identifying the area on the right ischial as a stage 1 pressure ulcer. The size and description were noted as 1.6 cm x 0.8 cm, red and blanching. On March 3, 2020, another assessment was completed by RN 2 describing the area on the right ischial as a stage 1 pressure ulcer. The size and description were noted as 1.5 cm x 0.8 cm, pink, blanching and intact. On March 5, 2020 at 9:28 PM, Licensed Practical Nurse (LPN) 2 assessed Resident 26's right ischial. When LPN 2 pressed on the reddened area the skin blanched. The are was also intact. According to the facility policy and NCBI national pressure ulcer staging system a stage 1 pressure ulcer needs to be intact skin with nonblanchable redness. Observation of the wound on March 5, 2020, in the presence of LPN 2, the wound was blanchable. Therefore, the wound would not meet the definition of a pressure ulcer. During an interview with the Director of Nursing on March 5, 2020 at 1:20 PM she stated that RN 1 did not have any specialized training for wound care but does attend a seminar annually. She confirmed that there are no competencies done for wound care. 28 Pa. Code 201.18 (e)(1)(2)(3) Management 28 Pa. Code 201.20 (a) Staff Development
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 clinical record review and staff interviews, it was determined that the facility failed to ensure residents using [MEDICAL CONDITION] medications received a gradual dose reduction for one of five residents reviewed for unnecessary medications (Resident 45). Findings Include: Review of Resident 45's clinical record revealed [DIAGNOSES REDACTED]. Review of Resident 45's current physician orders [REDACTED]. Review of Resident 45's form titled Psychoactive Medication Monitoring Form revealed that Resident 45 has been receiving a total of 2 mg of [MEDICATION NAME] per day, since February 2, 2015. Review of Resident 45's facility form titled Mood/Behavior/Psychoactive Drug Assessment, dated January 20, 2020, reviewing the time period of October 29, 2019-January 20, 2020, revealed that Resident 45 did not have any behaviors during those months. Review of Resident 45's behavior monitoring, delusion monitoring and hallucination monitoring, dated February 4, 2020-March 4, 2020, revealed Resident 45 did not display any behaviors, delusions or hallucinations during that time. Review of Resident 45's Behavior Management Plan, with an updated date of October 15, 2019, revealed Resident 45 has experienced decline in health which has decreased his level of activity and degree of interaction with others. There has been a significant reduction in target behaviors. Review of Resident 45's psychiatric consultation dated May 28, 2019, revealed Behavioral report looks good re: impulsive behaviors & depression. Staff have not expressed any concerns. Review of Resident 45's psychiatric consultation dated August 28, 2019, revealed excellent behavioral report. Review of Resident 45's psychiatric consultation, dated January 6, 2020, revealed that facility staff asked if Resident's [MEDICATION NAME] could be decreased due to increased sleepiness. A new order was received to change the dosing of the [MEDICATION NAME] from 1 mg twice a day to 0.5 mg in the morning and 1.5 mg at night, so Resident 45 would still be receiving 2 mg total per day. During an interview with Licensed Practical Nurse (LPN) 1, who is part of the facility's behavior team, on March 4, 2020, at 10:06 AM she stated that Resident 45 has had a lot of medical decline over the past year or two and his behaviors have gotten better and it has been a while since he's had an outburst. She stated that due to Resident's health decline, she feels that Resident wouldn't be capable of displaying the same aggressive behaviors he once displayed. She stated the facility has consulted with his psychiatrist about decreasing the [MEDICATION NAME] but that provider has declined to do so. LPN 1 stated that Resident 45 has a follow up psychiatric appointment in April and the facility will again make the recommendation to try a gradual dose reduction of Resident 45's [MEDICATION NAME]. On March 5, 2020, at approximately 11:50 AM the Nursing Home Administrator and Director of Nursing were made aware of the above. At approximately 1:15 PM the Director of Nursing confirmed that Resident 45 has been receiving 2 mg of [MEDICATION NAME] since February 2, 2015 and stated that he goes for another psychiatric appointment in April. She stated that Resident 45's provider from the facility defers to Resident 45's psychiatric provider regarding the [MEDICATION NAME]. 28 Pa. Code 211.2(a) Physician services.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, review of facility policies, and interviews with staff it was determined that the facility failed to store food properly and that staff failed to employ hygienic procedures while bussing dining room in accordance with professional standards for food safety. Findings include: During completion of facility main kitchen entrance tour on March 2, 2020, with Dietary Manager (DM) 1 the observation was made in walk-in freezer at 9:47 AM of four small boxes of collard greens out of original case box with no identifying information for date of being received. Also observed were one large bag of cauliflower, one large bag of diced carrots, one large bag of peas, one large bag mixed vegetables, one small bag yellow beans and one medium size bag stirfry blend vegetables which were all out of original case box and not dated with received date. During an interview with DM 1 during this observation , DM 1 stated that she didn't think that frozen vegetables had to be labeled when they were out of the case box. The facility failed to ensure that frozen vegetables were dated with receipt date upon removing from original case boxes (original case boxes have this information attached). The facility bussing cart contained cleaning supplies/clean gloves stored in close proximity to dirty dishware and trash. Continuation of the kitchen entrance tour revealed observation, while accompanied with DM 1, at 10:02 AM of small foodservice stainless steel three tiered cart in the kitchen, near the door leading into the dining room. It was observed that stored on the three shelves were bussing tubs containing dirty dish/glassware from the breakfast meal. It was observed that one end of the cart had an attached trash receptacle with plastic liner and contained paper trash and some discarded food items. It was observed that the other end of the cart had also an attached clean trash receptacle and contained boxes of gloves and wipes for cleaning tables. At this time, DM 1 was advised as to concern regarding clean items being in close proximity to contaminated items. Observation in facility main dining room on March 2, 2020, at 12:08 PM revealed that the bussing cart did not contain the clean gloves/wipes. Dietary aide (DA) 1 was observed utilizing the cart at this time wearing gloves. DA 1 was observed at this time to be clearing used plates and glassware from resident tables and was observed to touch her face to the side of her gloved hand, she then walked around and picked up a few used glasses, put

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