STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395518	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COURTYARD GARDENS NURSING AND REHAB CTR	**999 WEST HARRISBURG PIKE MIDDLETOWN, PA 17057**

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record reviews, interviews and resident rights it was determined that the facility failed to offer the option to formulate an advanced directive and provided no documentation pertaining to resident's choices for advanced directives, or documenting how the resident was informed of his/her right to develop a living will or advanced directive for three of 35 records reviewed (Residents 21, 32, and 71). Findings include: A review of the facility policy titled, Advance Directives, last reviewed February 2016, states, an Advance Directive is defined as a written document that a person may use, under certain circumstances, to tell others what care he or she would like to receive or not receive should he or she become unable to express his or her wishes. The facility policy states that Pennsylvania law recognizes 3 types of advance directives; a Living Will, also known as an Advance Directive; a Durable Power of Attorney for Health Care; and the PA-POLST. A review of the POLST form states that any individual for whom a POLST is completed should ideally have an advance health care directive that provides instructions for the individuals health care and appoints an agent to make medical decisions whenever the patient is unable to make or communicate a healthcare decision. The definition of a POLST form consists of a set of medical orders that applies to a limited population of patients and addresses a limited number of critical medical decisions. The form is intended as a complement to advance directives in that it serves as a translational tool and a continuity of care assurance. In contrast, an advance directive is a form in which an individual: (1) appoints a person or persons to make health care decisions for the individual if and when the individual loses the capacity to make health care decision (typically called a health care power of attorney); and/or (2) provides guidance or instructions for making health care decisions, typically in end-of-life care situations (often called a living will). An advance directive is a direction from the patient, not a medical order, (https://polst.org/about/polst-and-advance-directives). A review of Resident 21's clinical record revealed [DIAGNOSES REDACTED]. Review of Resident 21's clinical record revealed a POLST form was signed by the resident and the representative on [DATE], requesting: CPR (cardio-pulmonary resuscitation, full treatment, the use of antibiotics if life can be prolonged, a trial period of artificial hydration and nutrition by tube to be decided at that time, and was discussed with the resident. A review of Resident 21's clinical record failed to include a discussion regarding an Advance Directive. There was no Advance Directive/Living Will present in the clinical record. During an interview with the Director of Nursing on [DATE], at approximately 11: AM she stated that the facility replaced their previous Advance Directive form with the POLST. There was no documentation to show that the resident or representative was informed about the option to formulate a living will. During an interview on [DATE], at approximately 11:10 AM with the Director of Nursing it was revealed that Resident 21 doesn't have an Advance Directive/Living Will. Review of Resident 32's clinical record revealed [DIAGNOSES REDACTED]. Review of Resident 32's clinical record revealed a Pennsylvania Orders for Life-Sustaining Treatment (POLST) form was signed by the resident and the representative on [DATE], requesting: do not attempt resuscitation (DNR), limited additional interventions, the use of antibiotics if life can be prolonged, a trial period of artificial hydration and nutrition by tube to be decided at that time, and was discussed with the health care representative. Review of Resident 32's Durable Power of Attorney revealed her financial wishes and included the following medical authorization: her admission to a medical, nursing, residential or similar facility, and to enter into agreements for her care. And to authorize her medical and surgical procedures and arrange for and consent to medical, therapeutic and surgical procedures for her, including the administration of drugs, provided the action is in accordance with her wishes expressed in her living will, if any; signed [DATE]. Resident 32's Durable Power of Attorney failed to include her specific medical wishes; it referred to a living will which was not in Resident 32's clinical record. Resident 32's advanced care plan, as outlined by the resident's POLST not a living will/advanced directive, was reviewed by Certified Registered Nurse Practitioner 1 (CRNP 1), with Resident 32, her representative, and facility nurses on [DATE]. The facility replaced the advanced directive with the POLST. There was no documentation to show that the resident or representative was informed about the option to formulate an advanced directive/living will. A POLST [MEDICATION NAME] form is not an advance directive or living will. During an interview on [DATE], at approximately 11:10 AM with the Director of Nursing it was revealed that Resident 32 doesn't have a living will. A review of Resident 71's clinical record revealed [DIAGNOSES REDACTED]. Review of Resident 71's clinical record revealed a POLST form was signed by the resident's representative on [DATE], requesting: CPR (cardio-pulmonary resuscitation, full treatment; no antibiotics; long term artificial hydration and nutrition by tube; and was discussed with the representative. A review of Resident 71's clinical record failed to include a discussion regarding an Advance Directive. There was no Advance Directive/Living Will present in the clinical record. During an interview with the Director of Nursing on [DATE], at approximately 11:00 AM she stated that the facility replaced their previous Advance Directive form with the POLST. There was no documentation to show that Resident 71 or his representative was informed about the option to formulate a living will. During an interview on [DATE], at approximately 11:10 AM with the Director of Nursing it was revealed that Resident 71 doesn't have an Advance Directive/Living Will. 28 Pa. Code 201.18(a)(b)(1)(d)Management 28 Pa. Code 201.29(a) Resident Rights
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility document review, it was determined that the facility failed to ensure notification of change in health status was performed timely for one of 35 resident records reviewed (Resident 65). Findings include: Review of facility policy titled, Change in Resident Condition / Physician and Authorized Practitioner Notification, last revised May, 2015, revealed it was the facility's policy to, .notify the Physician and/or Authorized Practitioner and the resident's family and/or responsible party when there is a change in the condition of the resident. Review of subsection 5 of the aforementioned policy revealed it stated, Documentation will be made in the medical record regarding the resident's status, notification of the physician and family/responsible party. Review of Resident 65's clinical record on March 10, 2020 at approximately 10:30 AM, revealed [DIAGNOSES REDACTED]. Review of Resident 65's weight documentation revealed that between March 2, 2020 and March 3, 2020, Resident 65 had an increase in weight of 13.9 pounds. Review of Resident 65's interdisciplinary progress notes revealed no note regarding the weight gain was entered on March 3,

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) or March 4, 2020. On March 5, 2020 Registered Dietician 1 entered a progress note regarding the weight gain and stated, Concerned with such a large weight increase over a 24 hour time period for resident. Overall, resident is having reduced number of loose stools per day however, this would not be an adequate explanation for resident's large noted increase in a 24 hour time period. Discussed resident's weight gain with charge nurse on the unit. She will communicate the same to the physician to review when he rounds later today. Written notification also left for physician today . Review of the progress notes and physician progress notes [REDACTED]. Review of Resident 65's clinical record revealed a progress note dated March 9, 2020, (six days after the 13.9 pound weight increase) which stated, (Attending physician) in facility in AM, made aware of (resident) with significant (weight) gain . During a staff interview on March 12, 2020, at approximately 11:30 AM, Director of Nursing revealed that a 13.9 weight gain in a 24 hour period should have been communicated to the physician immediately. 28 Pa code 211.2(c) Physician services 28 Pa code 211.10(c) Resident care policies 28 Pa code 211.12(d)(1)(3)(5) Nursing services
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that the facility failed to maintain a clean, comfortable, and homelike environment by not having a policy or routine schedule for cleaning residents wheelchairs, and the observations of a soiled wheelchair during the initial tour, and the following day, for one of 35 residents reviewed, Resident 77. Findings include: A review of the clinical record for Resident 77 on March 9, 2020, revealed clinical [DIAGNOSES REDACTED]. Resident 77's most recent cognitive assessment stated that she has a BIMS (brief interview of mental status) score of 14 indicating that she is cognitively intact. During the initial tour on March 9, 2020, at 10:00 AM, Resident 77's Broda Chair (Broda is a wheelchair company that traditionally offers tilt-in-space positioning chairs for people in any type of healthcare setting, but commonly used in long term care/skilled nursing facilities or home care) was observed to be very soiled with what appeared to be food crumbs both on the cushion and leg rests. During an interview with Resident 77, she was asked if the facility cleans her wheelchair (Broda Chair) and cushions routinely, and she responded that she was unsure if the facility cleans her chair, she also stated, they say that they do, but I never see it cleaned. Observation on March 10, 2020, at 10:30 AM revealed Resident 77's Broda Chair with the same food crumbs as observed on March 9, 2020, in addition to many pieces of dried rice. Rice was served at a meal on March 9, 2020. During an interview with the Director of Nursing on March 11, 2020, at 3:07 PM she stated that staff are expected to clean resident wheelchairs when they are observed soiled. The Director of Nursing was also asked if the facility has a policy or housekeeping schedule for cleaning resident wheelchairs and she stated there is no policy or schedule for cleaning wheelchairs. On March 12, 2020, the Director of Nursing informed the surveyors that all wheelchairs in the facility were cleaned during the night shift on this date. Observation of Resident 77's chair at 8:45 AM revealed all of the cushions were removed for cleaning. 28 Pa Code 201.18(a)(3)(d) Management.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 two of 35 residents reviewed (Resident 73, and 84). Findings include: Based on review of the Resident Assessment Instrument (RAI- a standardized approach for applying a problem identification process in nursing homes, adopted to examine nursing home quality and to improve nursing home regulation) version 1.16, October 2018, pages L-1 through L-3: check L0200A, broken or loosely fitting full or partial denture: if the denture or partial is chipped, cracked, uncleanable, or loose. Review of Resident 73's clinical record revealed [DIAGNOSES REDACTED].(difficulty swallowing). During an interview on March 9, 2020, at approximately 10:00 AM with Resident 73 it was revealed that she has no natural teeth and that she was waiting for her denture to be fixed. Resident 73 was unsure how long she was waiting for her denture to be fixed. Resident 73's clinical record revealed her payor source was Medicaid pending as of June 14, 2019. Review of Resident 73's physician orders [REDACTED]. Further review of Resident 73's clinical record revealed a dental exam dated July 15, 2019; Doris was seen for initial exam. She is fully dentulous and only waring a full upper denture. #7 is missing from the full upper denture. Will PA for repair. Severe mand ridge (atrophy). Action required by Nursing Home Staff: assist with daily care as needed; tooth missing from full upper denture. PA for repair submitted. Review of Resident 73's care plan revealed the following intervention; Assist Doris with denture care AM & PM. Encourage her to complete what she can and assist as needed. Dentures are to be maintained for continued fit and resident comfort. Notify charge nurse if dentures are noted to be poorly fitted or have damage revision date June 17, 2019. Review of Resident 73's quarterly 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) with the assessment reference dates (last day of the assessment period) of September 11, 2019, December 4, 2019, and February 7, 2020, revealed in section L0200A - Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable or loose) was documented as No. During an interview on March 12, 2020, at approximately 11:20 AM with the Director of Nursing it was revealed that the aforementioned quarterly MDS assessments were not coded correctly. Review of Resident 84's clinical record on March 9, 2020, at approximately at approximately 1:00 PM, revealed [DIAGNOSES REDACTED]. Review of Resident 84's significant change Minimum Data Set (MDS - Assessment tool utilized to identify a residents' physical, mental, and psychosocial needs), assessment reference date of February 25, 2020, revealed that Resident 84 was coded as having a signficiant weight loss (more than 5% in 30 days or more than 10% in 6 months) in section K0300. Review of Resident documented weights over the six month time period prior to February 25, 2020, reveled no identified weight loss that equaled 5% in one month or 10% in six months. During an interview with Registered Dietician (RD) 1 on March 12, 2020, at approximately 10:30 AM, RD 1 stated that she must have calculated the weight loss incorrectly. During a staff interview on March 12, 2020, at approximately 11:30 AM, the facility had no further information to provide regarding the incorrect MDS coding for Resident 84. 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 clinical record review and staff interview, it was determined that the faciltiy failed to ensure a comprehensive plan of care was developed for the use of antipsychotics for one of 35 resident records reviewed (Resident 28). Findings include: Review of Resident 28's clinical record on March 9, 2020, at approximately 10:00 AM revealed [DIAGNOSES REDACTED]. Review of Resident 28's physician orders [REDACTED]. Review of Resident 28's clinical record revealed that at the time of the December 27th [MEDICATION NAME] order, Resident 28 was currently ordered [MEDICATION NAME] (an antipsychotic medication) 0.25 at bedtime. Review of Resident 28's physician orders [REDACTED]. Review of Resident 28's comprehensive plan of care revealed no care plan had been developed for the use of antipsychotic medications to include interventions specific for antipsychotics. During a staff interview on March 12, 2020, at approximately 11:30 AM, Director of Nursing revealed that a care plan for antipsychotics should have been implemented for Resident 28. 28 Pa code 211.11(d) Resident care plan 28 Pa code 211.12(d)(1) Nursing services
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview it was determined the facility failed to ensure resident services are provided or arranged to meet professional standards of practice for one of thirty-five residents reviewed (Resident 339). Findings Include: Review of Resident 339's clinical record revealed [DIAGNOSES REDACTED]. Review of Resident 339's interdisciplinary plan of care revealed a focus area addressing his need for [MEDICAL TREATMENT] treatment (a substitute for the normal function of the kidney where waste products and excess fluids are removed from the body) related to End Stage [MEDICAL CONDITION] (the final stage of [MEDICAL CONDITION] when the kidneys fail). Interventions on the interdisciplinary plan of care included Encourage (Resident 339) to go for the scheduled [MEDICAL TREATMENT] appointments. (Resident 339) receives [MEDICAL TREATMENT] Every Tuesday, Thursday , and Saturday. Review of Resident 339's March 2020 physician orders revealed none prescribed by his physician for Resident 339 to receive [MEDICAL TREATMENT] treatments. An

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) interview with the Director of Nursing on March 12, 2020, at 1:08 PM revealed the facility had no physician's order for Resident 339 to receive [MEDICAL TREATMENT] treatments. 28 Pa. Code 211.11 (d) Resident care plan 28 Pa. Code 211.12 (d) (1) (3) (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 observation, clinical record review, facility document review and staff interview, it was determined that the faclity failed to ensure treatment and services were provided to promote healing and prevent infection for one of 3 resident's reviewed for pressure injury (Resident 65). Findings include: Review of Resident 65's clinical record on March 10, 2020 at approximately 10:30 AM, revealed [DIAGNOSES REDACTED]. During wound dressing change observations for Resident 65 on March 11, 2020, at approximately 11:20 AM, LPN 2 was observed utilizing Resident 65's bedside table as the clean field (area utilized for supplies used during a clean or aseptic procedure) in preparation for the dressing change. Prior to placing supplies on a barrier on Resident 65's bedside table, LPN 2 did not cleanse the bedside table with an antimicrobial/antibacterial agent. After the dressing change supplies were laid out, LPN 2 washed her hands and donned gloves. LPN 2 then reached into the pockets in her clothing and produced a permanent marker. LPN 2 used the marker to write the date and initials on the foam dressing which would be placed over Resident 65's wound. LPN 2 then placed the cap onto the marker and placed the marker onto the clean field. Between approximately 11:20 AM and 11:32 AM, LPN 2 washed her hands and then used her right hand to advance the wall-hung paper towel holder to acquire paper towels, then donned gloves for wound treatment. During a staff interview on March 12, 2020, at approximately 11:30 AM, Director of Nursing revealed that the facility felt it was appropriate to place non-clean (marker) items on a clean-surface during a dressing change as long as the marker did not make contact with dressing supplies used on Resident 65. 28 Pa code 211.12(d)(1)(3)(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 observation, clinical record review, and staff interview, it was determined that the facility failed to ensure the resident environment was free of accident hazards for one of 35 residents reviewed (Resident 28). Findings include: Review of Resident 28's clinical record on March 9, 2020 at approximately 10:00 AM revealed [DIAGNOSES REDACTED]. During observations on March 9, 2020, at approximately 9:05 AM, it was revealed that Resident 28 was in bed with both side rails (bars/rails/enabler bars - item attached to the bed frame that extends laterally above the mattress and can be used for mobility purposes) in the up position. Observation of the side rails revealed that Resident 28's right side rail was missing black foam on the majority of the rail. Review of Resident 28's comprehensive plan of care revealed Resident 28 had a care with a focus of, At risk for skin impairment including: skin breakdown, pressure ulcers, skin tears, and bruising (related to) occasional (bowel and bladder) incontinent episodes, poor safety awareness, cognitive deficits, communication barrier, and antiplatelet use, which was initiated on March 4, 2016. Review of the care plan interventions revealed an intervention which stated, Bed frame padded to prevent injury during transfers, which was initiated on January 20, 2017. During an interview on March 12, 2020, at approximately 11:30 AM, Director of Nursing stated that the padding was to be replaced on Resident 28's bed rail. 28 Pa code 201.18(b)(1) Management 28 Pa code 211.12(d)(3)(5) Nursing services
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **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 ensure residents receive appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one of thirty-five resident records reviewed (Resident 83). Findings include: Review of Resident 83's clinical record revealed [DIAGNOSES REDACTED]. During an observation on March 9, 2020 at 9:52 AM Resident 83 was sleeping in bed, his urinary catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag) privacy bag (bag that covers the urinary catheter drainage bag to provide privacy)was hanging on his bed frame, and his urinary catheter drainage bag was lying on the floor . Review of facility policy titled, Foley (Urinary) Catheter Care, revised December 2014, states, to assist with the prevention of infection, the catheter bag and/or tubing should be kept off the floor. During an interview with the Director of Nursing on March 11, 2019, at approximately 1:32 AM revealed that Resident 83's urinary catheter drainage bag should not have been laying on the floor in accordance with facility policy. 28 Pa Code 201.14(a) Responsibility of Licensee 28 Pa Code 201.18(b)(1) Management 28 Pa Code 211.12(d)(1)(5) Nursing Services
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 clinical records, observations, and staff interviews, it was determined that the facility failed to provide respiratory services for two of thirty-five residents reviewed (Resident 1 and 66). Findings include: Review of Resident 1's clinical record revealed [DIAGNOSES REDACTED]. Observation of Resident 1 on March 9, 2020 at 9:24 AM revealed that she was using oxygen tubing dated March 1, 2020 (8days prior) and the tubing was connected to a humidifier bottle dated February 29, 2020 (9 days prior). Further observation of Resident 1 on March 9, 2020 at 11:43 AM revealed she was using oxygen tubing and nasal canula that were not dated. Review of Resident 1's current physician orders [REDACTED]. Review of the clinical record for Resident 66 on March 10, 2020, revealed [DIAGNOSES REDACTED]. A review of Resident 66's physician orders [REDACTED]. The orders also state to change the oxygen tubing, humidifier fluids and cannula every night shift, every Monday, and to date, initial, and label with the resident's name. During the initial tour of Resident 66's room on March 9, 2020, at 11:15 AM, observation included an oxygen concentrator with nasal cannula tubing and humidifier fluids connected to the oxygen concentrator. Both the nasal cannula tubing and the humidifier fluids were dated February 25, 2020. Observation on March 10, 2020 at 9:30 AM revealed the same date on both the nasal cannula tubing and the humidifier fluids. Observation on March 11, 2020 at 10:00 AM revealed the nasal cannula tubing and the humidifier fluids were dated March 10, 2020, indicating the tubing was changed after the observation on March 10, 2020 after the 9:30 AM observation. During an interview with the Director of Nursing on March 11, 2020, at approximately 2:15 PM she agreed the expectation that staff should follow the policy for changing the oxygen tubing and humidifier fluids weekly. 28 Pa. Code 211.10 (a)(c)(d) Resident care policies 28 Pa. Code 211.12 (c)(1)(d)(3)(5) Nursing services
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **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 residents requiring [MEDICAL TREATMENT] receive services consistent with professional standards of practice including ongoing assessment of the his or her condition and monitoring for complications before and after treatments for one of thirty-five residents reviewed (Resident 339). Findings Include: Review of Resident 339's clinical record revealed an admitted [DATE], with [DIAGNOSES REDACTED]. Review of Resident 339's interdisciplinary plan of care revealed a focus area addressing his need for [MEDICAL TREATMENT] treatment (a substitute for the normal function of the kidney where waste products and excess fluids are removed from the body) related to the End Stage [MEDICAL CONDITION] (the final stage of [MEDICAL CONDITION] when the kidneys fail). Review of Resident 339's March 2020 physician orders [REDACTED]. An interview with the Director of Nursing (DON), on March 12, 2020, at 11:44 AM revealed Resident 339 received [MEDICAL TREATMENT] services off-site on Tuesday, Thursday and Saturday although a physician's orders [REDACTED]. Further review of the physician orders [REDACTED]. Review of the facility's [MEDICAL TREATMENT] communication form, provided to the off-site [MEDICAL TREATMENT] treatment facility, revealed Resident 339's condition was not consistently completed by facility nursing staff upon each return to the facility post treatments on Tuesdays, Thursdays and Saturdays. An additional interview with the DON, on March 12, 2020, at 1:27 PM revealed no knowledge of the facility's communication form and revealed the forms would only be used to document Resident 339's weights and not for assessment of his condition upon return from [MEDICAL TREATMENT] treatments. 28 Pa. Code 211.11 (d) Resident care plan 28 Pa. Code 211.12 (d) (1) (3) (5) Nursing services

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F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3)
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, facility policy review, and staff interview, it was determined that the facility failed to ensure one of five residents reviewed were free of unnecessary medication (Resident 28). Findings include: Review of facility policy titled, Monitoring of Antipsychotics, (no date printed) revealed that the facility's policy was for, Residents receive antipsychotic medications only when medically necessary. Every effort is made to ensure that residents who use antipsychotics receive the intended benefit of the medications and to minimize the unwanted effects of the antipsychotic medications. Review of the aforementioned facility policy revealed that Procedure, stated, An antipsychotic medication should be used only for the following conditions/[DIAGNOSES REDACTED]. The stated indications included: [MEDICAL CONDITION], schizo-affective disorder, delusional disorder, mood disorders (e.g. mania, [MEDICAL CONDITION] disorder, depression with psychotic features, and treatment refractory [MEDICAL CONDITION]), schizophreniform disorder, [MEDICAL CONDITION] (sic), atypical [MEDICAL CONDITION], brief [MEDICAL CONDITION], dementing illnesses with associated behavioral symptoms, and medical illnesses or [MEDICAL CONDITION] with manic or psychotic symptoms and/or treatment-related [MEDICAL CONDITIONS](sic). The aforementioned policy continued with, In addition, the use of an antipsychotic must meet the criteria and applicable, additional requirements (listed in the policy). Subsection 1 stated, Criteria: Since [DIAGNOSES REDACTED]. The symptoms are identified as being due [MEDICAL CONDITIONS] (such as: auditory, visual, or other hallucinations; delusions (such as paranoia or grandiosity)); OR B: The behavioral symptoms present a danger to the resident or to others; OR C: The symptoms are significant enough that the resident is experiencing one or more of the following: Inconsolable or persistent distress (e.g., fear, continuously yelling, screaming, distress associated with end-of-life, or crying); a significant decline in function; and/or substantial difficulty receiving needed care (e.g., not eating resulting in weight loss, fear and not bathing leading to skin breakdown or infection). Subsection 2 of aforementioned policy stated, Inadequate indications: In many situations, antipsychotic medications are not indicated. They should not be used if the only indications is one or more of the following: 1) wandering; 2)poor self-care; 3) restlessness; 4) impaired memory; 5) mild anxiety; 6) [MEDICAL CONDITION]; 7) unsociability; 8) inattention or indifference to surroundings; 9) fidgeting; 10) nervousness; 11) uncooperativeness; or 12) verbal expressions or behavior that are not due to the conditions listed under 'Indications' and do not represent a danger to the resident or others. Review of Resident 28's clinical record on March 9, 2020, at approximately 10:00 AM revealed [DIAGNOSES REDACTED]. Review of Resident 28's interdisciplinary progress notes, specifically Behavior Note(s) on March 11, 2020, at approximately 12:45 PM, revealed that between January 1, 2019 to December 27, 2019, Resident 28 had behaviors documented on February 8, 2019, February 19, 2019, May 21, 2019, and July 10, 2019, and December 27, 2019 (the day in which the [MEDICATION NAME] medication was ordered). Review of Behavioral Health practitioner progress note, with encounter date of November 20, 2019, revealed the practitioner documented, (Resident 28) is being seen for med(ication) check. Staff report she is stable, no new issues. Review of Resident 28's clinical record on March 9, 2020, at approximately 10:00 AM revealed that Resident 28 was ordered [MEDICATION NAME] (an antipsychotic medication). Upon further review, it was revealed that Resident 28 was ordered 0.25 milligrams (mg - metric unit of measure) on December 27, 2019 which was clarified by the physician on and ordered [MEDICATION NAME] 25 mg at bedtime on December 28, 2019. Review of the December 27, 2019 behavior note revealed it stated, Resident is actively exit seeking. Attempted to leave building (twice) by front door. Exit prevented by receptionist. Resist redirection by raising fist to staff and swearing at them. Social Services aware. Self propelling in halls looking for exits. Attempts to redirect to supper, clam approach and attempts by different staff members attempted without improvement. Wanderguard bracelet (electronic device that produces a proximity alarm when close to exit doors) applied for safety. (Attending physician) notified. New order for [MEDICATION NAME] 0.25 mg (clarified and changed to 25 mg on December 28, 2019) (by mouth twice a day) received. Review of the progress note and all available information provided by the facility revealed no indication for an antipsychotic medication per the facility's policy between July 10, 2019 to and on December 27, 2019. Further, review of Resident 28's medication regimen for December 27, 2019, revealed that Resident 28 was already receiving [MEDICATION NAME] (an antipsychotic medication) 0.25 mg at bedtime. Between the dates of December 28, 2019 and February 21, 2020, Resident was receiving duplicate therapies of antipsychotic medications. Review of Behavioral Health practitioner progress note, with encounter date of February 19, 2020, revealed that the Mental Health Practitioner documented, Patient recently started on [MEDICATION NAME] by (Primary Care Provider) for increased general restlessness, however she was already on [MEDICATION NAME] 0.25 mg at (sic) bedtime. Review of the HPI area revealed that Mental Health Practitioner documented, Patient being seen for medication check, staff reports that in past 2 weeks patient has been restless and agitated. She has been aggressive and combative with care. Staff reports this is really out of hand. She was seen wheeling herself up and down the hallway staff reports she can go like that all day she is also observed to be very short tempered. Review of available documentation revealed no indication or symptoms for the antipsychotic use, nor duplicative therapies. Between March 11, 2020 and March 12, 2020 at 1:00 PM, State Surveyor made 5 requests for behavior documentation leading up to December 27, 2019. As of March 12, 2020, the facility provided no documented indication for the antipsychotic [MEDICATION NAME], no documentation of hallucinations, or delusions (indicators of [MEDICAL CONDITION]), or documentation that Resident 28 was a danger to herself or anyone else between July 10, 2019 and December 27, 2019. As of March 12, 2020 at 1:00 PM, the facility had no further information to provide. 28 Pa code 211.2(c) Physician services 28 Pa code 211.12(d)(3)(5) Nursing services
F 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain dental services for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined that the facility failed to provide routine and emergency dental services for one of 35 residents reviewed (Resident 73). Findings: Review of Resident 73's clinical record revealed [DIAGNOSES REDACTED].(difficulty swallowing). During an interview on March 9, 2020, at approximately 10:00 AM with Resident 73 it was revealed that she has no natural teeth and Resident 73 stated she was waiting for her denture to be fixed. Resident 73 was unsure how long she was waiting for her denture to be fixed. Resident 73's clinical record revealed her payor source was Medicaid pending as of June 14, 2019. Review of Resident 73's physician orders [REDACTED]. Further review of Resident 73's clinical record revealed a dental exam dated July 15, 2019; Doris was seen for initial exam. She is fully dentulous and only waring a full upper denture. #7 is missing from the full upper denture. Will PA for repair. Severe mand ridge (atrophy). Action required by Nursing Home Staff: assist with daily care as needed; tooth missing from full upper denture. PA for repair submitted. Review of Resident 73's care plan revealed the following intervention; Assist Doris with denture care AM & PM. Encourage her to complete what she can and assist as needed. Dentures are to be maintained for continued fit and resident comfort. Notify charge nurse if dentures are noted to be poorly fitted or have damage revision date June 17, 2019. During an interview March 12, 2020, at approximately 1:25 PM the Director of Nursing revealed that the prior authorization was started, however she was not sure the status of the authorization. It was also revealed that there is not a follow up visit scheduled. During an interview on March 12, 2020, at approximately 1:40 PM the Director of Nursing revealed the facility does not obtain the prior authorization, because they don't bill for the dental services. 28 Pa Code 211.15(a) Dental services
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.** Based on observation, review of facility policy, and interview it was determined that the facility failed to store and serve food/beverages in accordance with professional standards for food safety for four of four panty refrigerators and one of three reach-in refrigerators in the kitchen area. Findings include: Review of facility policy for Dress Code, revised

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395518	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COURTYARD GARDENS NURSING AND REHAB CTR	**999 WEST HARRISBURG PIKE MIDDLETOWN, PA 17057**

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) February 8, 2013, revealed Fingernails must be clean and short in order to prevent bacteria growth Regular nail polish over natural nails will not be permitted. Observation in the dry storeroom on March 9, 2020, at approximately 9:00 AM one bag of pasta shells, and one bag of pot pie shells that were open with contents partially removed and not securely closed. During an interview on March 9, 2020, at approximately 9:00 AM with Food Service Director 1 (FSD 1) it was revealed that the aforementioned bags should be securely closed. During an interview on March 11, 2020, at approximately 3:00 PM it was revealed that the aforementioned bags should be securely closed. Observation in the main dining room area on March 9, 2020. at approximately 9:13 AM the following items were thawed and didn't contain a thaw or use by date: 1 carton of chocolate nutritional supplement; and 1 carton of Sugar Free strawberry banana nutritional supplement. The packaging of the aforementioned products instructed to use within 14 days of being thawed. During an interview with the Food Service Director 1 (FSD 1) on March 9, 2020, at approximately 9:13 AM it was revealed that once the frozen nutritional supplements are removed from the freezer they are put on a tray and the tray is dated and stored in the main kitchen. Staff will pull items from the main kitchen refrigerator to stock the dining room and the pantries. Observation in Nourishment pantry 2 on March 9, 2020, at approximately 9:15 AM the following items were thawed and didn't contain a thaw or use by date: 9 sugar free strawberry banana nutritional supplements; 5 chocolate nutritional supplements. 3 apple cranberry nutritional supplements; and 5 orange nutritional supplements. Observation in Nourishment pantry 1 on March 9, 2020, at approximately 9:25 AM the following items were thawed and didn't contain a thaw or use by date: 1 carton apple cranberry nutritional supplement; and 1 carton of orange nutritional supplement. During an interview on March 11, 2020, at approximately 3:14 PM with the Nursing Home Administrator it was revealed that the aforementioned items should be dated when pulled from the freezer or thawed. Observation on March 9, 2020, at approximately 11:52 AM in the main dining room Dietary aide 1 (DA 1), had long nails with blue nail polish and was not wearing gloves. DA 1 was behind the steam table serving the noon meal and multiple times touched the top rim of multiple the plates with her thumb. During an interview of March 9, 2020, at approximately 12:08 PM with FSD 1 revealed that staff should not wear gloves when serving, and that the staff should not touch the top of the plate just the side of the plate. During an interview on March 11, 1020, at approximately 3:15 PM with the Nursing Home Administrator it was revealed expectation is to follow the aforementioned dress code and to not touch the top of the plate with a bare hand. Observation in the kitchen prep area on March 10, 2020, at approximately 9:10AM and March 11, 2020, at approximately 12:59PM it was noted that the screens on the windows contained a brown fuzzy substance, the aforementioned substance was also strung from the screen to the outer edge of the window sill, and on the wall above the window, the windows were not open, a stack of sheet trays were stored faced down under the window. During an interview on March 11, 2020, at approximately 12:59PM with Food Service Director 1 (FSD 1) it was revealed that it is the responsibility of the Dietary and/or the Maintenance department to clean the aforementioned area. During an interview on March 11, 2020, at approximately 3:00 PM with the Nursing Home Administrator it was revealed that Dietary and Maintenance are responsible for cleaning the windows/screens and it is expected that the aforementioned area should be clean. 28 Pa code 211.6(b)(d) - Dietary Services
F 0868 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Based on review of facility documentation and staff interview it was determined that the faciltiy failed to ensure the quality assessment and assurance committee consisted of the Medical Director. or his designee for one, of four quarterly meeting minutes reviewed (September 2019). Findings Include: Review of the faciltiy's form titled QAPI Monthly Meeting Attendance, dated September 2019, revealed no signature of attendance by the facility's medical director or his designee. An interview with the QAPI Coordinator, LPN 1, on March 12, 2020, at 10:08 AM confirmed the medical director, or designee, was not present during the facility's September 2019 quarterly meeting. 28 Pa. Code 201.14 (a) Responsibility of Licensee 28 Pa. Code 201.18 (a) 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.** Based on observation and staff interview it was determined that the facility failed to ensure infection control policies and procedures were implemented to prevent the potential spread of infectious disease for one of 4 units observed (C unit). Findings include: During observations on March 11, 2020, at approximately 11:35 AM, Nurse Aide (NA) 2 was observed transporting a biohazard bag to the C unit's soiled utility room. Once in the soiled utility room, NA 2 was observed discarding the biohazard bag then utilizing soap and water to wash her hands. After washing her hands, NA 2 used her left hand to open the lid of a trashcan, which contained a mixture of soiled debris, to discard the used paper towels. NA 2 then exited the soiled utility room. NA 2 was then observed entering a resident room on the C unit, without utilizing any hand-sanitizer. During a staff interview on March 11, 2020, at approximately 11:30 AM, the facility had no further information to provide regarding NA 2 utilizing a washed hand on the soiled utility room's trashcan lid to discard the used paper towels. 28 Pa code 201.18(b)(1)Management 28 Pa code 211.12(d)(1) Nursing services