STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395585	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRANSITIONS HEALTHCARE NORTH HUNTINGDON	**8850 BARNES LAKE ROAD NORTH HUNTINGDON, PA 15642**

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 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to accommodate the residents' needs by failing to ensure the proper positioning needed for eating for one of 31 residents reviewed (Resident 7) who had nutritional and self-care concerns. Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated May 4, 2020, indicated that the resident required assistance with eating and a mechanically altered diet. Current [DIAGNOSES REDACTED]. The resident's care plan, dated April 30, 2020, revealed that she was to be in a Broda chair (an adaptive wheelchair) in the upright position when eating, and a nutritional risk care plan, revised on June 16, 2020, revealed that she was to be provided with set-up and assistance as needed to eat. Observations during the lunch meal on June 22, 2020, at 1:30 p.m. revealed that Resident 7 was sitting in a Broda chair beside her bed with a tray table at eye level. The Broda chair was not in the upright position. The resident was eating with her fingers and could not reach most of her meal. Interview with Nurse Aide 2 on June 22, 2020, at 1:30 p.m. confirmed that Residents 7's Broda chair was not in the upright position and the resident was having difficulty eating and was unable to reach the food. Nurse Aide 2 then replaced the table with one that could be lowered and positioned the Broda chair in an upright position. Interview with the Assistant Director of Nursing on June 22, 2020, at 4:10 p.m. confirmed that the meal set-up was not appropriate to accomodate Resident 7's needs. 28 Pa. Code 211.12(d)(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 clinical record reviews and staff interviews, it was determined that the facility failed to ensure the proper wound care was provided as ordered by the physician for one of 31 residents reviewed (Resident 11). Findings include: A [DIAGNOSES REDACTED]. physician's orders [REDACTED]. Resident 11's Treatment Administration Record (TAR) and nursing notes for April 2020 revealed no documented evidence that physician-ordered treatments to the sacral area were provided, or why they were not provided as ordered, on April 10, 13, 17 and 25, 2020. Interview with Registered Nurse 1 on June 22, 2020, at 2:15 p.m. confirmed that there was no documented evidence that the sacral wound treatments were completed on the above days as ordered by the physician. She indicated that nursing staff were to document on the TAR when treatments were provided. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0742 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.** **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 the attending physican was notified timely regarding medication recommendations for one of 31 residents reviewed (Resident 30). Findings include: A [DIAGNOSES REDACTED]. physician's orders [REDACTED]. physician's orders [REDACTED]. There was also an order [REDACTED]. The consulting physician recommended that the resident's [MEDICATION NAME] be increased to 20 mg daily and that [MEDICATION NAME] be increased to 15 mg at bedtime. There was no documented evidence that Resident 30's attending physician was notified about these medication recommendations until May 12, 2020 (11 days after the psychiatric evaluation), at which time there were orders given for [MEDICATION NAME] to be discontinued and for [MEDICATION NAME] to be increased to 15 mg daily at bedtime. Interviews with the Director of Nursing on June 23, 2020, at 2:45 p.m. and 3:15 p.m. confirmed that there was no evidence that the attending physican was notified about the psychiatrist's recommendations for medication changes until May 12, 2020, and that a nurse should have notified the attending physician promptly. 28 Pa. Code 211.12(d)(3)(5) Nursing services.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of guidance from the Centers for Disease Control and the Pennsylvania Department of Health, review of the facility's policies and procedures and resident's clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that staff used correct personal protective equipment (PPE) while providing care and/or services to four of 31 residents reviewed (Residents 11, 22, 23, 24) who were placed on droplet precautions, and failed to ensure that proper infection control practices were used during the screening process for visitors and staff, and during blood sugar monitoring for one of 31 residents reviewed (Resident 25). Findings include: The Pennsylvania Department of Health - Health Alert Network (PAHAN) 509, updated May 29, 2020, included that residents with a negative COVID test, who remain asymptomatic but are within 14 days of possible exposure to COVID-19, were to be placed in a Yellow Zone and that full PPE (protective garments and/or equipment designed to protect the body from infection or injury) was to be worn when caring for these residents. Guidance from the Centers for Disease Control (CDC - a national health protection agency) regarding the use of PPE for Coronavirus Disease 2019 (COVID-19 - an infectious disease caused by [MEDICAL CONDITION], that can cause fever, cough, fatigue and/or breathing problems), dated May 22, 2020, included that when caring for a person with confirmed or suspected COVID-19, the caretaker was to use eye protection, and that the preferred PPE for eye protection was a face shield or goggles. The facility's guidelines regarding COVID-19 precautions, dated March 3, 2020, indicated that droplet precautions (special infection control procedures used when a person has an infection with germs that can be spread to others by speaking, sneezing or coughing) would be implemented for residents with suspected or confirmed COVID-19, until lifted by the Infection Preventionist and Physician. The facility's policy regarding droplet precautions, dated December 2019, included that residents suspected to be infected with a microorganism that can be spread by droplets should be put in droplet isolation. A sign on Resident 24's door indicated that the resident was under droplet precautions and the instructions for a person entering the room included to clean the hands before entering the room and prior to exiting the room; to make sure the eyes, nose and mouth were fully covered before entering the room; and to remove face protection before exiting the room. The PPE located on the resident's door included gowns, gloves, face shields, and medical masks. Observations on June 22, 2020, at 12:18 p.m. revealed that Nurse Aide 2 started to enter Resident 24's room without putting on a gown, gloves, or eye protection, until reminded by Registered Nurse 5 that she must do so. Nurse Aide 2, who was already wearing a face mask, then put on gloves and a gown, but did not put on eye protection prior to entering the resident's room. Interview with Nurse Aide 2 on June 22, 2020, at 1:07 p.m. confirmed that she did not wear appropriate eye protection when entering Resident 24's room. She thought that isolation precautions were removed for the resident. Nurse Aide 2 then spoke with Registered Nurse 5, who stated that droplet precautions were removed for the resident next

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) door but not for Resident 24. Observations on June 22, 2020, at 12:27 p.m. revealed that Nurse Aide 3 entered Resident 24's room with a mask, gloves and a gown on; however, she was not wearing eye protection. Observations on June 22, 2020, at 12:45 p.m. revealed that during the process of meal delivery, Nurse Aide 3 entered Resident 24's room with a mask on, but she did not put on gloves, a gown or protective eye wear. Interview with Nurse Aide 3 on June 22, 2020, at 1:07 p.m. confirmed that she did not put on appropriate PPE when delivering Resident 24's meals. The nurse aide stated, I had gloves on. However, the observation revealed that the nurse aide did not put on gloves prior to entering Resident 24's room. Observations on June 22, 2020, at 12:50 p.m. revealed that during the process of trash collection, Housekeeper 4 entered Resident 24's room with a mask and one glove on; however, she did not put a glove on the other hand and did not put on a gown or protective eye wear. Housekeeper 4 emptied two trash cans, one closer to the door and another one closer to Resident 24. Interview with Housekeeper 4 on June 22, 2020, at 1:10 p.m. confirmed that she should have put on the appropriate PPE as indicated by the sign and supplies posted on the door, but she did not think it was necessary due to the quickness of entering and exiting the room. Interview with Registered Nurse 5 on June 22, 2020, at 1:15 p.m. confirmed that staff were to follow infection control precautions according to policy, as Resident 24 was recently admitted from the hospital. Interview with the Assistant Director of Nursing on June 22, 2020, at 2:14 p.m. confirmed that Resident 24 was on droplet precautions and all staff should be putting on appropriate PPE (gloves, gown, mask and faceshield) before entering the resident's room. Observations of Resident 11's room door on June 22, 2020, at 12:40 p.m. revealed that the resident was on contact and droplet precautions. Observations at 12:42 p.m. revealed that Nurse Aide 12 had a mask on and put on a gown and gloves prior to entering the resident's room; however, she entered the room without eye protection on. Interview with the Assistant Director of Nursing on June 22, 2020, at 2:10 p.m. confirmed that Nurse Aide 12 should have applied a face shield before entering Resident 11's room because the resident was on droplet isolation precautions. Admission information for Resident 22 revealed that the resident was admitted to the facility on [DATE], and a nursing admission evaluation dated June 20, 2020, revealed that the resident was on isolation precautions. Observations on June 22, 2020, at 12:10 p.m. revealed that Activity Aide 13 was standing by the resident's bed and she had regular eye glasses on but did not have a face shield or goggles on. Upon interview with Activity Aide 13 on June 22, 2020, at 12:26 p.m. she indicated that she wears only her own eyeglasses when visiting residents on the unit and felt that she only needed wear a faceshield or goggles if the resident was positive for COVID-19. Admission information for Resident 23 revealed that the resident was admitted to the facility on [DATE]. Observations on June 22, 2020, at 12:08 p.m. revealed that there was a sign on the resident's room door indicating that he was on droplet precautions and prior to entering the room, staff were to make sure that their eyes, nose and mouth were covered. There was PPE hanging on the resident's door that included face shields and goggles. Observations on June 22, 2020, at 12:08 p.m. revealed that Nurse Aide 14 was in Resident 23's room and he did not have eye protection on. Interview with Nurse Aide 14 on June 22, 2020, at 1:10 p.m. revealed that he did not see the face shields on the resident's door and he should have put one on prior to entering the resident's room. Observations on June 22, 2020, at 12:45 p.m. revealed that Nurse Aide 15 entered Resident 23's room without eye protection on and prepared the resident's lunch meal. Interview with Nurse Aide 15 on June 22, 2020, at 12:58 p.m. confirmed that she should have put eye protection on before entering Resident 23's room. Interview with the Assistant Director of Nursing on June 22, 2020, at 2:05 p.m. confirmed that for residents in droplet precaution rooms, staff were to put on goggles or a faceshield, even if the staff person has on regular eyeglasses. The facility's policy regarding blood glucose (sugar) monitoring, dated March 5, 2020, included that the glucometer (device used to read the glucose level in a blood sample) was to be cleaned and disinfected after each use and between each resident. A [DIAGNOSES REDACTED]. The nurse then left the resident's room and laid the glucometer directly on top of the medication cart, removed her gloves, opened the cart, and placed the glucometer inside the medication cart without cleaning it. Interview with Licensed Practical Nurse 6 on June 22, 2020, at 12:23 p.m. confirmed that she should have cleaned the glucometer immediately after using it. The facility's policy regarding mask use by employees, dated June 1, 2018, indicated that direct care employees in the facility were to wear masks to limit the potential spread of infection from employees and employees to residents. The facility's policy regarding staff education for COVID-19, dated April 8, 2020, indicated that staff were to maintain social distancing and employees were required to wear a mask (covering the mouth and nose) at all times when in the building. Observation upon entering the facility on June 22, 2020, at 8:35 a.m. revealed that postings indicated that masks were to be used by all that enter past the area of screening (entry area). Observations on June 22, 2020, at 3:10 p.m. revealed that without a mask on, Licensed Practical Nurse 7 walked down the hallway past the therapy department, through the dining room where residents were located, and then into the administrative offices area. Interviews with Licensed Practical Nurse 7 and the Director of Nursing on June 22, 2020, at 3:20 p.m. and 3:50 p.m., respectively, confirmed that Licensed Practical Nurse 7 should have had a mask on. The facility's policy regarding undiagnosed respiratory illness and COVID-19, dated March 10, 2020, indicated that the mode of transmission included indirect contact via hand transfer of [MEDICAL CONDITION] from [MEDICAL CONDITION] contaminated surface or object to the mucosal surface of the face, and that different modes of transmission of COVID-19 transmission were unclear. Upon entry to the facility on [DATE] at 8:35 a.m., observations revealed that all who entered the facility were instructed to fill out a screening form on the table regarding any symptoms and any history of exposure to COVID-19. The pen on the table was used by Dental Visitor 11, who then laid the pen back on the table for reuse by others. The pen was not cleaned or disinfected. Observations on June 22, 2020, at 10:04 a.m. revealed that Occupational Therapist 8 used the pen on the table to sign out of the building and laid it back on the table for reuse without disinfecting. Interview with Receptionist 7 on June 22, 2020, at 10:15 p.m. revealed that the facility did not have a process in place to disinfect the pens after being used. 28 Pa. Code 211.12(d)(1)(5) Nursing services.