STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39A435	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHEASTERN PENNSYLVANIA VETERAN'S CENTER	**ONE VETERANS DRIVE SPRING CITY, PA 19475**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, and staff interview, it was determined that the facility failed to follow up on an x-ray (a form of electromagnetic [MEDICAL CONDITION] that is used for medical imaging) order in a timely manner, resulting in a delay of treatment for one of three residents reviewed (Resident CL1). Findings include: Review of Resident CL1's [DIAGNOSES REDACTED]. A review of Resident CL1's vital signs record revealed that the Resident had a temperature of 99.8 Fahrenheit (F) (normal temperature range: 97 F to 99 F) on April 16, 2020, at 2:35 p.m. A review of Resident CL1's nursing progress note dated April 17, 2020, at 2:32 a.m., revealed Resident had a temperature of 101.3 F, [MEDICATION NAME] (a medication to treat fever and mild pain) was given, generalized weakness was noted. A review of Resident CL1's physician's orders [REDACTED]. The patient is facing towards the left on the lateral view). A review of the same order sheet revealed that the order for Resident CL1's chest x-ray was faxed to the radiology provider on April 17, 2020, at 2:17 p.m. A review of Resident CL1's POS revealed another order for PA/lateral chest x-ray on April 19, 2020, at 10:40 a.m. Review of Resident CL1' s nursing progress note dated April 19, 2020, at 1:15 p.m., revealed Chest x-ray ordered, tech (radiology technician) with the Resident at present. Review of nursing progress note dated April 19, 2020, at 1:49 p.m. revealed, provider and POA was given an update on chest x-ray result which was Patchy Bibasilar (relating to bases of both lungs) increased density suggest atelectasis (complete or partial collapse of a lung or a section of a lung) and pneumonia (a lung disease characterized by inflammation of the airspaces in the lungs, most commonly due to an infection). Review of the same note revealed that a new order of [MEDICATION NAME] (an antibiotic used to treat many different types of infections caused by bacteria), and [MEDICATION NAME] (a medication that can decrease the pain and swelling of arthritis, also used to treat and prevent [DIAGNOSES REDACTED] (mosquito-borne disease caused by a parasite) was obtained, POA was made aware. A statement from the Nursing Home Administrator on July 16, 2020, at 8:07 a.m., revealed that the initial order (chest x-ray) was written on April 17, 2020, but upon follow up with the radiology provider, they stated that they did not receive the order on April 17, 2020. The order was re-written on April 19, 2020, and the x-ray was done on the same day. During an interview with a nursing supervisor, Employee E4, on July 16, 2020, at 12:50 p.m., regarding the process of receiving an order for [REDACTED]. Employee E4 further stated that for a non-STAT (immediate) chest x-ray order, if the provider did not come in to do the procedure within 24 hours from the time the x-ray was ordered, a follow-up call should be made and the physician should be notified to get a new order. A review of Resident CL1's clinical records failed to reveal that the physician was notified of the delayed chest x-ray until April 19, 2020. Review of Resident CL1's progress notes dated April 19, 2020, at 10:44 p.m., revealed that the Resident was started on a treatment for his/her pneumonia ([MEDICATION NAME]) that was identified from the chest x-ray result on April 19, 2020, two days after the initial chest x-ray was ordered by the physician on April 17, 2020, at 2 p.m. The above finding was conveyed with the NHA on July 16, 2020, at 2:08 p.m. The facility failed to follow up on a chest x-ray order in a timely manner resulting in a delay of treatment for Resident CL1. 28 Pa. Code 211.12(c)Nursing services Previously cited 10/10/19 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services Previously cited 10/10/19, 6/9/20

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.