STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395902	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORMANDIE RIDGE	**1700 NORMANDIE DRIVE 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, policy review, and record review it was determined that the facility failed to provide information to the resident that explains the duration of bed-hold, the reserve bed payment policy, or that addressed permitting the return of the resident to the next available bed, for one of 3 residents reviewed with hospital transfers, (Resident 41). Findings include: A review of the facility policy titled, Bed Hold last revised April 2018, states that Medical Assistance Residents who leave the facility for hospitalization will have their bed reserved the maximum number of days permitted by the Pennsylvania Medical Assistance Program. If the residents hospital stay exceeds the number of days permitted, the resident, if returning to the facility, will be entitled to the first available room suitable for the resident's level of care. The facility policy also states that following the lapse of the bed reservation period covered by the Medical Assistance Program, a resident may reserve a bed by electing to pay the per diem rate charged immediately prior to the transfer, and by providing written notice and advance payment for the days included in the reservation period. A review of the closed clinical record for Resident 41 on March 3, 2020, at 9:00 AM revealed clinical [DIAGNOSES REDACTED]. A review of the clinical record for R 41 on March 3, 2020, revealed a progress note that stated R 41 was transferred to the hospital on January 27, 2020, after being found unresponsive. A copy of the bed holds notice was requested from the facility on March 3, 2020. During an interview with the Nursing Home Administrator on March 4, 2020, at approximately 2:00 PM, she confirmed there was no notice of bed-hold provided at the time of the transfer, or within 24 hours, provided to Resident 41, or to her representative, specifying the duration of the bed-hold, or information regarding the reserve bed payment policy, per diem rates, or that addressed the return of the resident to the next available bed when discharged from the hospital. The expectation of the Nursing Home Administrator was that the bed-hold notice should have been provided to the resident or resident's representative within 24 hours of the transfer. 28 Pa. Code 201.29(a)(f) Resident rights.
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 clinical record review and staff interview it was determined that the facility failed to ensure each resident receives treatment and care with professional standards of practice for two of thirteen residents reviewed (Residents 13 and 58). Findings Include: Review of Resident 13's March 2020 physician orders [REDACTED]. Further review of Resident 13's physician orders [REDACTED]. 201-250=4 units. Review of Resident 13's Medication Administration Record [REDACTED]. The documentation revealed staff administered 6 units of [MEDICATION NAME] instead of the physician ordered 4 units for coverage. An interview with the Director of Nursing, on March 5, 2020, at approximately 1:30 PM revealed she could not find any nursing notes to support the administration of Resident 13's [MEDICATION NAME] by staff outside of the physician ordered parameters. Review of Resident 58's clinical record on March 3, 2020 at approximately 9:30 AM revealed [DIAGNOSES REDACTED]. Review of Resident 58's physician orders [REDACTED]. It was observed that a bag of saline solution 0.9% (a solution that is utilized to dilute IV medications and/or for treatment of [REDACTED]. Connected to the saline solution 0.9% bag was a vial which had a manufacturers liable that revealed it was meropenem 1 gram. It was observed that the vial was approximately half-full of an unidentified solution. During an interview with Registered Nurse (RN) 1 on March 3, 2020 at approximately 10:14 AM, it was revealed that RN 1 did not a administer the dose of IV antibiotics that was currently on the machine, how ever, RN 1 stated that she had experience providing the medication to Resident 58 and that there should be no solution left in the vial. During the interview, RN 1 stated she did not disconnect the IV tubing from Resident 58, further, it would have been the prior shift's Registered Nurse Supervisor that would have administered the medication and subsequently disconnected the IV tubing. RN 1 confirmed that the vial appeared to be half-full with solution and stated that during administration of the antibiotic the vial should be completely emptied for the dose Resident 58 was ordered. Review of facility policy titled, Reconstitution (adding a solution to a powered medication) of medication for [MEDICATION NAME] (IV) Administration, last revised May 2003, revealed it was the facility's stated policy that, (The facility staff are to) provide for the safe and accurate reconstitution of parental medications prior to administration. Subsection 11 of the policy stated, Note refusal or administration of less than 100% of dose in the 'Nurse's Medication Notes' (in the Resident's medication administration record). Review of Resident 58's clinical record including the Medication Administration Record [REDACTED]. During a staff interview on March 6, 2020 at approximately 11:15 AM, Director of Nursing revealed it was the facility's expectation that all order medications are provided as ordered and that the staff that disconnected Resident 58's IV should have observed the IV medication to confirm the entirety of the medication was infused. 28 Pa code 211.12(d)(1)(5) Nursing services
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interview, it was determiend that the facility failed to assess the resident for risk of entrapment and review the risks and benefits prior to the installation of bed rails for one of thirteen residents reviewed (Resident 13). Findings Include: Review of Resident 13's March 2020 physician orders [REDACTED]. An observation in Resident 13's room, on March 2, 2020 at 10:21 AM revealed two enabler bars attached to his bed. Review of Resident 13's clinical record revealed no measurements conducted by staff to assess Resident 13's risk of entrapment. Further review of the clinical record revealed no risks/benefits reviewed with Resident 13 or his responsible party. An interview with the Nursing Home Administrator, on March 5, 2020, at 11:45 AM revealed Resident 13 is a readmission to the facility and confirmed the consent and risk benefits forms should have been reviewed during this current readmission to the facility. 28 Pa. Code 201.18 (b) (1) Management 28 Pa. Code 211.5 (f) Clinical Records 28 Pa. Code 211.12 (d) (5) Nursing services

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395902	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORMANDIE RIDGE	**1700 NORMANDIE DRIVE 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0700 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, manufacturer information, facility documentation, and staff interview, it was determined that the facility failed to record the open date of medications on two of two medication carts (Sunflower medication cart and Tulip medication cart) and failed to discard expired medication on one of two medication carts (Sunflower medication cart). Findings Include: Observation of the Sunflower medication cart on [DATE] at 11:32 AM revealed one [MEDICATION NAME] (insulin- medication to lower blood sugar) [MEDICATION NAME] in use with no open date and one [MEDICATION NAME] in use with an open date of [DATE] (55 days earlier). Observation of Tulip medication cart on [DATE] at 12:00 PM revealed [MEDICATION NAME] with no open date and one [MEDICATION NAME] (insulin- medication to lower blood sugar) Flextouch Pen with no open date. Review of facility provided pharmacy information revealed that a [MEDICATION NAME] should be discarded 28 days after it has been removed from refrigerated storage and a [MEDICATION NAME] should be discarded 42 days after it has been removed from refrigerated storage. Review of manufacturer information for [MEDICATION NAME] indicates that unused [MEDICATION NAME] Flextouch pens stored at room temperature should be thrown away after 28 days and in use [MEDICATION NAME] Flextouch pens should be stored at room temperature and thrown away after 28 days, even if it still has insulin left in it. Review of manufacturer information for [MEDICATION NAME] Flextouch pen indicates, Unrefrigerated [MEDICATION NAME] Flextouch should be discarded 42 days after they are first kept out of the refrigerator. Interview with the Director of Nursing on [DATE] at 11:01 AM, revealed that she would have expected the insulin pens would have been dated when removed from the refrigerator and that expired pens would have been properly disposed of in accordance with manufacturer guidelines. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1)(i) Pharmacy services. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.
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, policy review, and interview, it was determined that the facility failed to maintain a safe and sanitary environment during dining observation that supports infection prevention and control for two of 3 dining observations during lunch, (March 2, 2020 and March 4, 2020). Findings include: A review of the facility policy titled, Food Safety Standards and Requirements, last revised January 8, 2020, states the following, ready-to-eat food must not be touched with bare hands. Disposable gloves or cleaned, sanitized utensils must be used properly to handle food. Observation during the lunch dining on March 2, 2020, Staff Licensed Practical Nurse 1 was observed picking up Resident 37's peanut butter and jelly sandwich, with her bare hands, and handing it to the resident. Observation during the lunch dining on March 4, 2020, Staff Nurse Aide 1 was observed picking up Resident 43's chicken salad sandwich, with her bare hands, and handing it to the resident. During an interview with the Nursing Home Administrator and the Director of Nursing on March 4, 2020, at 2:06 PM she confirmed that ready-to-eat foods should never be touched with bare hands. 28 Pa. Code 201.18(a)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services