STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395828	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAMBRIA CARE CENTER	**429 MANOR DRIVE EBENSBURG, PA 15931**

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 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to treat residents with dignity by failing to respect a resident's right to retain and use personal possessions for one of 12 residents reviewed (Resident 1), and failing to answer call bells timely for one of 12 residents reviewed (Resident 7). Findings include: The facility's policy regarding residents' personal property, dated June 1, 2020, revealed that a personal belongings inventory would be maintained for all residents, and that the inventory list would be updated by nursing staff when new items were brought in to the resident. A comprehensive admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated July 3, 2020, revealed that the resident was severely cognitively impaired, required limited assistance from staff to perform daily care tasks, and that it was very important for him to take care of his personal belongings. A facility Personal Inventory form for Resident 1, dated June 26, 2020, which was the resident's admission day, listed one electric razor with a charger and one pair of glasses with a case. There was no evidence that the resident had any personal clothing in his possession during his stay. The form was signed by the resident's representative and a staff witness upon the resident's discharge on July 21, 2020. A Labeling Form from the laundry department, dated June 28, 2020, revealed that four shirts, three t-shirts, five pair of pants, three pair of socks, one black belt, one hat, one pair of slippers, and one duffel bag were labeled with Resident 1's name and specific room number, which was not the room the resident resided in during his stay from June 26 to July 21, 2020. Interview with the Personal Laundry Assistant Supervisor on July 29, 2020, at 8:55 a.m. revealed that Resident 1's clothing was received, washed, and labeled. However, the clothing was labeled with the wrong room number and was sent to the wrong floor. The interview revealed that Resident 1 was not provided with his clothing during his stay in the facility, it was found and sent with him at discharge, but he was discharged in a gown. Interview with the Nursing Home Administrator on July 29, 2020, at 3:05 p.m. confirmed that Resident 1's personal clothing was not provided to him and he wore double gowns throughout his stay. Admission information revealed that Resident 7 was newly admitted to the facility on [DATE], at 7:52 p.m., and a baseline care plan, dated July 28, 2020, revealed that she was cognitively intact, had an open area on the upper buttocks, and was incontinent of bowel and bladder. physician's orders [REDACTED]. Interview with Resident 7 on July 29, 2020, at 3:22 p.m. revealed that she rang her call bell because she was wet, and on two separate occasions staff came into the room, turned the call bell off, said that they would be back, never provided any care, and never returned. The resident stated that she had been waiting for about an hour and was now soiled. Observations on July 29, 2020, from 3:22 p.m. to 3:35 p.m. revealed that Resident 7's call bell light was lit and ringing. No staff responded to the resident's call bell until 3:35 p.m. Nurse Aide 1 arrived and searched the room, but there were no supplies in the room. Nurse Aide 1 returned at 3:48 p.m. with supplies to provide care. Observations of Resident 7 on July 29, 2020, at 3:50 p.m. revealed that the resident had been incontinent of bowel and urine. The resident was wearing a gown and lying on a blue cloth pad. Nurse Aide 1 provided incontinent care, and applied a protective skin cream and an adult brief. During incontinent care, Resident 7 complained that the left side of her buttock was painful. Interview with Nurse Aide 1 on July 29, 2020, at 4:07 p.m. revealed that the blue cloth pad was saturated with urine and feces and the resident needed incontinent care. Interview with the Assistant Director of Nursing on July 29, 2020, at 16:35 p.m. revealed that staff needed to answer residents' call bells as soon as possible. 28 Pa. Code 201.29(j) Resident rights. 28 Pa. Code 211.12(d)(5) Nursing services.
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 resident's preferences for a shower for one of twelve residents reviewed (Resident 4). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated July 14, 2020, indicated that the resident was cognitively intact and was totally dependent on one staff for bathing. Current [DIAGNOSES REDACTED]. Physician orders [REDACTED]. Resident 4's care plan, revised on March 5, 2020, indicated that the resident had a preference for showers on Tuesdays and Saturdays during the day shift (7:00 a.m. to 3:00 p.m.). A care plan revision on May, 20, 2020, related to the resident's risk of falls, indicated that the resident was to be transferred using a large sling with a full body mechanical lift (device that uses hydraulic power to lift and move a person from surface to surface). Interview with Nurse Aide 2 on July 28, 2020, at 1:00 p.m. revealed that a bariatric (large) sling was not available to shower Resident 4. Staff called the laundry department at approximately 9:00 a.m. to have one sent to the floor, but as there was no sling available, Nurse Aide 2 planned to give Resident 4 a bed bath instead of a shower. Interview with Resident 4 on July 29, 2020, at 11:05 a.m. revealed that the resident was provide a bed bath and not a shower on Tuesday, July 28, 2020. Resident 4 stated, I was supposed to but there was not enough big ones (slings), and I wanted one. Interview with the Nursing Home Adminstrator on June 29, 2020, at 4:30 p.m. confirmed that Resident 4 should have been provided with a shower instead of a bed bath on July 18, 2020, in accordance with her preference. 28 Pa. Code 211.12(d)(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.** Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to provide a clean and homelike environment in residents' rooms for three of 12 residents reviewed (Residents 7, 8, 10), and failed to provide a clean environment in the shower room on the 100 unit hall. Findings include: The facility's tray delivery log, revised April 10, , revealed that lunch trays for rooms 126-133 were to be delivered at 11:30 a.m. Observations of Resident 7's room on July 29, 2020, at 3:22 p.m. revealed that a lunch tray remained in the resident's room. Observations of Resident 8's room on July 29, 2020, at 3:13 p.m. revealed that a lunch tray remained in the resident's room. Resident 8 pushed his tray away and stated, Take it. I don't want it here. Observations of Resident 10's room on July 29, 2020, at 3:12 p.m. revealed that a lunch tray remained in the resident's room. Interview with Nurse Aide 1 on July 29, 2020, at 4:00 p.m. indicated that staff on the second shift (3:00 p.m. to 11:00 p.m.) routinely collect residents' lunch trays. Interview with the Nursing Home Administrator on July 29, 2020, at 4:01 p.m confirmed that the lunch trays should not have been left in the residents' rooms. Observations in the toilet/shower room on the 100 hall on

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) July 28, 2020, at 12:55 p.m. revealed that there was a used brief on the floor, two used towels and a lift sling on a shower litter, a used towel lying over the bath tub, a used glove on the bariatric shower litter, a piece of gauze, small pieces of plastic debris and an empty shampoo bottle on the floor, and there was urine in the toilet. Interview with Nurse Aide 1 on July 29, 2020, at 1:00 p.m. confirmed that the shower room was to be cleaned after each resident was showered. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29(j) Resident rights. 28 Pa. Code 207.2(a) Administrator's responsibility.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that observations and assessment of a resident's respiratory condition was completed according to physician's orders [REDACTED]. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated July 14, 2020, revealed that the resident was alert and oriented, used oxygen, had a [MEDICAL CONDITION] (surgically created airway in the windpipe), and required suctioning. A grievance filed by Resident 2, dated July 12, 2020, indicated that she needed to be suctioned more prior to meal time, and that staff had difficulty hearing her through closed doors. It was discussed that her room could be moved closer to the nursing station, but she was still concerned with the doors being closed. The possibility of staff checking on the resident every hour was discussed. physician's orders [REDACTED]. Interviews with the Assistant Director of Nursing and Nursing Home Administrator on July 29, 2020, at 4:01 p.m. confirmed that there was no documented evidence that Resident 2 was observed and assessed every hour as ordered by the physician. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** Based on review of facility policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to ensure that residents' food preferences were honored for one of 12 residents reviewed (Resident 3). Findings include: The facility's policy regarding food preferences, dated June 1, 2020, indicated that nursing staff would inform the kitchen about resident requests and preferences as needed. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated May 26, 2020, indicated that the resident was able to make herself understood, was able to understand others, and was alert and oriented. Observations of Resident 3's dinner tray on July 29, 2020, at 4:51 p.m. revealed that the resident received one roast beef and cheddar sandwich. Interview with Resident 3 at that time, and observations of the copy of the selected menu that she had previously completed and gave to the activity department, revealed that she had requested two roast beef and cheddar sandwiches. Interview with the Nursing Home Administrator on July 29, 2020, at 6:40 p.m. confirmed that Resident 3 completed a menu and requested two roast beef and cheddar sandwiches, but dietary staff did not receive her request from the activities department. 28 Pa. Code 201.29(j) Resident rights.
F 0807 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents were provided with fresh fluids each shift for four of 12 residents reviewed (Residents 3, 7, 8, 9). Findings include: The facility's policy regarding hydration, dated June 1, 2020, indicated that residents would be provided with a mug or disposable cup and the container was to be refilled every shift with water and/or ice and water. A first floor education form, undated, revealed that everyone was to have fresh fluids passed on every shift. An education for all nursing staff, dated June 15, 2020, indicated that water was to be passed on all three shifts, which was to be done timely, and staff were not to wait until the end of their shift to pass water. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated May 26, 2020, indicated that the resident was alert and oriented and could eat independently. Observations on July 29, 2020, at 10:40 a.m. revealed that Resident 3 had a styrofoam cup for water on her overbed table that was labeled July 29 11-7 indicating that the cup and water were provided during the night shift (11:00 p.m. to 7:00 a.m.). Observations on July 29, 2020, at 3:12 p.m. revealed that the same styrofoam cup labeled July 29 11-7 remained on the resident's overbed table. Interview with Resident 3 at that time confirmed that staff did not provide her with fresh water during the day shift (7:00 a.m. to 3:00 p.m.). Resident 7's clinical record revealed that the resident was newly admitted to the facility, and a baseline care plan, dated July 28, 2020, indicated that the resident was alert, cognitively intact and required set-up for meals. Observations on July 29, 2020, at 3:22 p.m. revealed that there was a styrofoam cup on the side table that was labeled July 29 11-7. Interview with the resident at that time confirmed that staff did not provide her with fresh water during the day shift. A quarterly MDS assessment for Resident 8, dated July 13, 2020, indicated that the resident was understood, could understand, and required set up and supervision for eating. The resident's care plan, dated March 16, 2020, indicated that the resident was at risk for constipation due to immobility and staff were to ensure increased fiber and fluids to provide more bulk in the diet. Observations on July 29, 2020, at 3:15 p.m. revealed that there was a styrofoam cup on the overbed table that was labeled July 29 11-7. A quarterly MDS assessment for Resident 9, dated June 30, 2020, indicated that the resident was cognitively intact and required set up and supervision for eating. The resident's care plan, dated March 9, 2020, indicated that the resident had a history of [REDACTED]. Observations on July 29, 2020, at 11:05 a.m. revealed that Resident 9 had a styrofoam cup for water on his overbed table that was labeled July 29 11-7. Observations on July 29, 2020, at 3:10 p.m. revealed that the same styrofoam cup dated July 29 11-7 remained on the resident's overbed table. Interview with the resident at that time confirmed that staff did not provide him with fresh water during the day shift. Interview with Nurse Aide 1 on July 29, 2020, at 3:30 p.m. confirmed that the resident's water cups were label from the night shift and the day shift staff did not provide fresh water and/or ice for the residents. Interview with Licensed Practical Nurse 4 on July 29, 2020, at 3:26 p.m. confirmed that fresh water was to be provided to the residents every shift. Interview with the Nursing Home Administrator on July 29, 2020, at 4:01 p.m. confirmed that fresh water should be passed to the residents every shift. 28 Pa. Code 211.12(d)(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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Department of Health directives, facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that the proper infection control practices were followed regarding personal protective equipment (PPE) when entering an isolation room for two of 12 residents reviewed (Residents 11, 12), and failed to screen residents for fever and/or decreased oxygen levels (symptoms of COVID-19) for three of 12 residents reviewed (Residents 2, 3, 4). Findings include: The facility's policy regarding isolation for residents during the COVID-19 pandemic, dated March 10, 2020, indicated that staff entering the rooms of residents who were on droplet precautions (special infection control procedures to prevent the spread of germs that are normally spread by coughing and sneezing) were to wear full PPE (gloves, gown, face shield/goggles, and masks (respirators if available - an N-95 mask - a special type of protective mask that removes 95 percent of organisms and contaminants in the air)), upon entering a resident's room and when caring for the resident. physician's orders [REDACTED]. Interview with Nurse Aide 3 at that time confirmed that he entered the residents' room to place linens in the room without wearing an N-95 mask. Inteview with the Assistant Director of Nursing, who was responsible for infection control, on July 29, 2020, at 2:55 p.m. confirmed Nurse Aide 3 should have worn an N-95 mask when entering the room of Residents 11 and 12. The facility's policy regarding COVID-19, dated June 1, 2020, indicated that staff were to be alert to the signs of COVID-19 and to notify the resident's physician of a fever, cough, or shortness of breath. PAHAN (Pennsylvania Health Alert Network) 509, dated June 1, 2020, indicated that facilities should actively screen all residents for fever and COVID-19 symptoms at least daily, and test any resident who exhibited fever or symptoms consistent with COVID-19. A staff education directive, dated March 30, 2020, indicated that all residents should have their pulse oximetry (percentage of oxygen in the blood) and temperature taken on

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) the day shift, and a pulse oximetry taken in the evenings. An education for all nursing staff, dated June 15, 2020, indicated that temperatures and pulse oximetry were to be done on all residents twice daily by the nurses. A temperature log for Resident 2 for June and July 2020, revealed that there was no documented evidence that the resident's temperature was obtained on June 5, 8, 22 and 26, and July 6, 8 and 27, 2020. A temperature log and pulse oximetry log for Resident 3 for June and July 2020, revealed that there was no documented evidence that the resident's temperature was obtained on June 5, 8, 14 and 28, and July 6 and 27, 2020; and there was no documented evidence that the resident's pulse oximetry was obtained on June 13, 14, 28 and 29, and July 2, 6, 8, 13, 16, 26 and 27, 2020. A temperature and pulse oximetry log for Resident 4 for June and July 2020 revealed that there was no documented evidence that the resident's temperature was obtained on June 5, 14, 22, 25, 26 and 28, and July 6 and 27, 2020; and there was no documented evidence that the resident's pulse oximetry was obtained on June 22, 26 and 28, 2020. Inteview with the Assistant Director of Nursing, who was responsible for infection control, on July 29, 2020, at 2:55 p.m. confirmed that residents' temperatures and pulse oximetry were to be taken at a minimum of once a day. 28 Pa. Code 211.12(d)(1)(5) Nursing services.