| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395530 | A. BUILDING _____ B. WING _____ | 03/12/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| PRESBYTERIAN HOMES-PRESBY | 220 NEWRY STREET HOLLIDAYSBURG, PA 16648 |

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 0607<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Develop and implement policies and procedures to prevent abuse, neglect, and theft.**<br><br>Based on review of policies, Pennsylvania laws and personnel records, as well as observations and staff interviews, it was determined that the facility failed to implement its abuse prevention policies by failing to ensure that Pennsylvania State Police background checks were completed for ten of ten privately hired agency companions (Companions 1-10). Findings include: The facility's abuse policy, dated January 10, 2020, revealed that residents were not to be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. Criminal background checks were required for each new employee prior to the first day of employment. Chapter 5, Section 502(a)(1) of Pennsylvania Act 169, dated December 18, 1996, indicated that a criminal history report was to be obtained from the State Police for all applicants, and Section 501 defined State Police as The Pennsylvania State Police. Section 506 indicated that the facility could employ applicants on a provisional basis for a single period not to exceed 30 days if the applicant has applied for the Pennsylvania State Police criminal history record and the applicant provides a copy of the request form. Observations on March 9, 2020, at 11:50 a.m. revealed that Resident 1 had a private companion with her. An interview with the Director of Nursing on March 9, 2020, at 2:30 p.m. revealed that Resident 1's spouse hired an agency to provide companionship for his wife each day. A total of ten agency companions had been scheduled to sit with Resident 1 since February 1, 2020. There was no documented evidence that the facility conducted criminal background checks on the companions prior to their first day in the facility. Interview with the Nursing Home Administrator on March 11, 2020, at 3:30 p.m. confirmed that there were no criminal background checks completed for Companions 1-10 prior to working in the facility. 28 Pa. Code 201.18(e)(1) Management. |
| F 0641<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure each resident receives an accurate assessment.**<br><br>Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate comprehensive Minimum Data Set assessments for two of 29 residents reviewed (Residents 8, 32). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, revealed that if the assessment was the first assessment since the most recent admission/entry or reentry, then Section A0310E was to be coded one (1) - Yes. Section J1700, the resident's fall history on admission/entry or re-entry, was to be completed if Section A0310E was coded one (1) - Yes. If the resident had a fall any time in the last month prior to admission/entry or reentry, then Section J1700A was to be coded one (1) - Yes. If the resident had a fracture related to a fall in the six months prior to admission/entry or re-entry, then Section J1700C was to be coded one - (1) Yes. An investigation report for Resident 8, dated February 21, 2020, at 4:45 p.m. revealed that the resident fell in her bathroom when attempting to transfer herself from her wheelchair to the toilet. The resident's left foot and ankle were deformed and positioned almost sideways under the toilet. The resident was transferred to the hospital and had a fractured left ankle. A quarterly MDS assessment for Resident 8, dated March 2, 2020, revealed that Section A0310E was incorrectly coded zero (0) - No, indicating that this was not the resident's first MDS assessment since being readmitted . By coding Section A0310E as zero (0), the computerized MDS software did not allow Sections J1700A and J1700C to be completed to reflect that the resident had a fall and fracture in the past 30 days. Interview with Registered Nurse Assessment Coordinator 11 (RNAC - a registered nurse who is responsible for the completion of MDS assessments) on March 12, 2020, at 5:33 p.m. confirmed that Resident 8's fall and fracture on February 21, 2020, was not captured on the quarterly MDS assessment of March 2, 2020, and should have been. The RAI User's Manual, dated October 2019, revealed that Section H0600 (Bowel Patterns), was to be coded with a zero (0) - No or one (1) - Yes, depending on if the resident showed signs of constipation during the seven-day look back period. The definition of constipation was if the resident had two or fewer bowel movements during the 7-day look-back period, or if for most bowel movements the stool was hard and difficult to pass (no matter what the frequency of bowel movements was). A comprehensive annual MDS assessment for Resident 32, dated January 20, 2020, revealed that Section H0600 was coded with a zero (0), indicating that the resident showed no signs of constipation during the seven-day look back period (January 13-19, 2020). However, the resident's bowel records for January 13-29, 2020, revealed that she had only two documented bowel movements during the 7-day look back period. Interview with RNAC 11 on March 12, 2020, at 11:23 a.m. confirmed that Resident 32 had only two bowel movements during the MDS look-back period. She indicated that she coded Section H0600 as a zero (0) because she interpreted the RAI Manual instructions to mean that as long as the bowel movements were not hard or difficult to pass that constipation should not be coded, regardless of the frequency. 28 Pa. Code 211.5(f) Clinical records. |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record reviews and staff interviews, it was determined that the facility failed to develop comprehensive care plans that included specific and individualized interventions to address the care needs of one of 29 residents reviewed (Resident 8). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated March 2, 2020, revealed that the resident received an anticoagulant medication (a medication that thins the blood to prevent clots). physician's orders [REDACTED]. Administration Records (MAR's) for March 2020 revealed that the resident received [MEDICATION NAME] on March 1 through 11, 2020. There was no documented evidence that a care plan was developed to address Resident 8's specific and individualized care needs related to receiving an anticoagulant medication. Interview with the Director of Nursing on March 12, 2020, at 3:31 p.m. confirmed that an individualized care plan and interventions were not developed related to Resident 8 receiving anticoagulant medication. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code 211.12(d)(5) Nursing services. |
| F 0658<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure services provided by the nursing facility meet professional standards of quality.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on review of the Pennsylvania Nursing Practice Act and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that a professional (registered) nurse completed an assessment of a resident following a change in condition for one of 29 residents reviewed (Resident 36). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing |

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 0658<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>care actions that promote, maintain and restore the well-being of individuals. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 36, dated February 3, 2020, revealed that the resident had severely impaired cognition, required limited assistance with walking, used a wheelchair, had a history of [REDACTED]. She was not wandering around per her baseline normal. There was no documented evidence that a registered nurse assessed Resident 36 when she was noted to be lethargic. An investigation report, dated December 29, 2019, at 12:15 p.m. revealed that Resident 36 was getting up from the dining room table and fell to the floor. She had an abrasion to her forehead and a skin tear to the bridge of her nose. A nursing note dated December 29, 2019, at 12:57 p.m. revealed that the resident slept in, was tired, and was unsteady per the nurse aide. She was placed in a wheelchair for dining and was taken to the dining room and fell out of her wheelchair, causing an injury to her face and right arm. There was no documented evidence that a registered nurse assessed Resident 36 when she was unsteady. Interview with the Director of Nursing on March 12, 2020, at 6:52 p.m. confirmed that there was no documented evidence of a registered nurse assessment of Resident 36 when she was lethargic and unsteady, and confirmed that the nurse aide should not have put the resident in her wheelchair and taken her to the dining room without a registered nurse assessing her on December 29, 2020. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services. |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice by failing to follow physician's orders [REDACTED]. Findings include: The facility's bowel management program, dated January 10, 2020, indicated that if the resident did not have a bowel movement per their normal routine, staff were to follow the specific physician-ordered bowel protocol for the resident. physician's orders [REDACTED].) if there was no bowel movement every fifth day if the MOM was ineffective. Resident 32's bowel movement records for September and October 2019 revealed that the resident did not have a bowel movement from September 28 through October 6, 2019 (nine days). The resident's Medication Administration Records (MAR's) for October 2019 revealed that staff administered a dose of MOM on October 1, 2019, at 1:22 p.m., and again on October 1, 2019, at 9:19 p.m. Interview with the Director of Nursing on March 12, 2020, at 2:21 p.m. confirmed that staff should not have administered two doses of MOM in eight hours to Resident 32 on October 1, 2019. 28 Pa. Code 211.12(d)(1)(5) Nursing services. |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on review of policies, clinical records, and the facility's investigation documents, as well as staff interviews, it was determined that the facility failed to provide adequate supervision, monitoring, and/or assistance devices to prevent accidents for two of 29 residents reviewed (Residents 1, 48). Findings include: The facility's policy regarding falls, dated January 10, 2020, indicated that each resident was to be provided with an appropriate assessment and interventions to prevent falls and to minimize complications if a fall would occur. The facility was to ensure the resident environment remained as free of accident hazards as possible. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated September 5, 2019, revealed that the resident was severely cognitively impaired, required the assistance of two staff for bed mobility and transferring from one position to another, had balance problems, and had [DIAGNOSES REDACTED]. Resident 1's care plan, dated December 3, 2018, indicated that she was at high risk for falls due to a history of stroke, confusion and a lack of safety awareness, and she required assistance with all transfers. Staff were to anticipate her needs, assist with activities of daily living as needed, provide constant safety reminders, and slipper socks at all times. An incident/accident investigation report, dated November 27, 2019, revealed that at 8:30 a.m. the hospice caregiver (staff from an agency that provides end-of-life care) was providing morning care to Resident 1, sat her up on the side of her bed, and she slid off the bed onto the floor. The resident received a laceration above the right eye, a skin tear on her right shin, and a raised area above her right eye. A statement from Nurse Aide 14, dated November 27, 2019, revealed that she sat Resident 1 up on the side of the bed and when she sat her up, the resident yelled and slid out of bed, hitting the floor on her right side. A nursing note, dated November 28, 2019, at 2:43 p.m. revealed that Nurse Aide 14 sat Resident 1 up after dressing her and she began to lean. Nurse Aide 14 reported that she tried to stop the fall but Resident 1 fell to the floor. Interview with the Director of Nursing on March 12, 2020, at 2:15 p.m. confirmed that Resident 1 required two staff for bed mobility and Nurse Aide 14 should not have sat her up on the side of the bed by herself. A quarterly MDS assessment for Resident 48, dated February 13, 2020, indicated that the resident had clear speech, was able to be understood, was usually able to understand others, was severely cognitively impaired, required supervision for mobility about the nursing unit, and had [DIAGNOSES REDACTED]. A behavior care plan for Resident 48, dated July 9, 2018, identified that Resident 48 had a history of [REDACTED]. physician's orders [REDACTED]. Information submitted by the facility, dated October 4, 2019, revealed that on October 3, 2019, at 6:50 p.m. Resident 48 exited in her wheelchair through the fire doors at the end of the main corridor to the second floor nursing unit and was found on the landing between the two flights of steps with her wheelchair on top of her. The resident was transported to the emergency room where diagnostic studies revealed a collapsed spinal vertebra (bone of the spinal column) that may or may not have been preexisting. The resident returned to the facility on [DATE], at 2:05 a.m. A skin assessment revealed that the resident had one hematoma (collection of blood under the skin), 13 bruises, two staples to the back of her head, a laceration to the left knee, and four skin tears including one above the right eye that was glued with (medical) adhesive. The facility initiated behavior logs for 72 hours (staff were to document any behaviors - attempts to go out exits) and the IDT was to assess these behaviors and care plan for additional interventions. The information also indicated that one staff member would be monitoring the resident's behaviors for 72 hours beginning October 4, 2019, and that as of October 7, 2019, there were no behaviors noted due to the resident being in bed. Resident 48's care plan was updated in October 2019 to include interventions such as providing a coloring book for enjoyment, providing a snack when she wanders, offering a baby doll or soft animal to hold, redirecting to a pleasurable activity when exit seeking, and implementing a 72-hour behavior log as needed to document if the resident was going toward the doors. A Task Administration Record Report for Resident 48, for July 2019 through March 12, 2020, revealed that staff documented that the resident had No Behaviors for all three shifts every day. Review of IDT notes revealed that as of October 24, 2019, Resident 48 had not been wandering since her fall, but had been more able to move her wheelchair since feeling better. A nursing note dated October 26, 2019, revealed that the resident was exit seeking after lunch but was effectively redirected. A nursing note dated November 8, 2019, at 2:06 p.m. revealed that Resident 48 was observed pushing down on the door handle and was easily redirected. A note dated November 15, 2019, at 1:51 p.m. revealed that the resident was exit seeking through the door by the Assistant Director of Nursing's office and the licensed practical nurse redirected her to come back and eat lunch, noting that the alarm was sounding at the time of the incident and the resident holds the bar down until the door opens, then she holds the door open and self-propels through. IDT notes dated December 20, 2019, indicated that staff noted that wandering had declined, and a note dated January 3, 2020, indicated that though the resident had no documentation of wandering in the past week, the resident still wanders at times. An IDT note dated January 10, 2020, indicated that the resident still continued to wander at times and staff attempted to redirect her with one-to-one conversation, holding a baby doll, sitting in the dining room with other residents, and activities, again noting that no wandering behaviors were documented in the past week. An IDT note dated January 31, 2020, revealed that the resident continued to trigger for behaviors due to wandering at times, becoming restless, and stating she needs to find her husband or kids. The resident's daughter stated that even when she is visiting, the resident wanders away from her. Staff try many diversional activities; however, the resident has a very short attention span and usually only stays engaged for a few minutes, and even with one-to-one does not engage well. An IDT note dated February 21, 2020, revealed that staff noted that the resident had less wandering behaviors, and a February 28, 2020, IDT note indicated that there was no wandering in the past week. The most recent recent IDT note, dated March 8, 2020, revealed that the resident continued to roam up and down |

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| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>the hallway and into other residents' rooms since the last review, and hospice staff (end-of-life services) were now visiting in the early evenings, which tended to be the time she wandered more. Interview with Nurse Aide 15 on March 12, 2020, at 1:26 p.m. confirmed that Resident 48 still wanders to the exit doors but she has only observed this once in a great while. The nurse aide indicated that there was no place for nurse aides to document wandering or exit seeking behaviors in the resident's chart, and that wandering behaviors were to be passed on to the licensed practical nurse in charge that shift. Interview with Nurse Aide 16 on March 12, 2020, at 1:43 p.m. revealed that she had to redirect Resident 48 away from the exit doors approximately eight to ten weeks ago. The nurse aide indicated that there was no place for nurse aides to document wandering or exit seeking behaviors in the resident's chart, and that wandering behaviors were to be passed on to the licensed practical nurse. Interview with Nurse Aide 13 on March 12, 2020, at 2:35 p.m. revealed that he was very familiar with Resident 48 and was routinely assigned to her care. He confirmed that the resident continued to wander to the exit doors by the stairwell and he had to redirect her away from the exits a couple of times a week. The nurse aide indicated that there was no place for nurse aides to document wandering or exit seeking in the resident's chart, and that wandering behaviors were to be passed on to the licensed practical nurse. Interview with Nurse Aide 17 on March 12, 2020, at 2:45 p.m. revealed that he has had to redirect Resident 48 from the stairwell two to three times since being assigned to the second floor. Interview with Licensed Practical Nurse 18 on March 10, 2020, at 1:00 p.m. revealed that behavior monitoring/tracking records were kept in a binder in the nursing station, and each resident who was being monitored for behaviors was to have their own record. The licensed practical nurses were to record the behaviors on the individual resident's record. He confirmed that Resident 48 did not have any current behavior monitoring/tracking record in the binder and he was not aware of any recent behaviors or exit seeking by Resident 48. Interview with Licensed Practical Nurse 19 on March 12, 2020, at 3:30 p.m. revealed that staff have not reported any wandering or exit seeking behaviors by Resident 48 to him. Interviews with the Nursing Home Administrator and the Director of Nursing on March 12, 2020, at 12:47 p.m. confirmed that the Task Administration Record Report for Resident 48 for July 2019 through March 12, 2020, revealed that staff documented No Behaviors on all three shifts every day from July 2019 through and including March 20, 2020, and that there was only sporadic documentation of exit seeking behaviors in the resident's IDT and nursing notes. They believed that their current interventions were effective in preventing exit seeking for Resident 48. They confirmed that nurse aides were to report attempts at exit seeking to the licensed practical nurse in charge, and they were not aware of any of the above attempts at exit seeking that were described by the nurse aides, and these occurrences should have been communicated and documented for the IDT to review. The facility's policy regarding transferring a resident, dated January 10, 2020, revealed that foot rests were to be used whenever the resident did not self-propel the wheelchair. A quarterly MDS assessment for Resident 48, dated February 13, 2020, indicated that the resident was severely cognitively impaired and required supervision for mobility about the nursing unit. Observations on March 9, 2020, at 3:02 p.m. revealed that Hospice Nurse Aide 12 pushed Resident 48 in her wheelchair from in front of the restroom door, past the nursing station and dining area, and down the next hall to the resident's room. During this transport, there were no foot rests in place on the wheelchair, and the resident's feet were in contact with the floor, gliding across the floor, as she was being pushed. When Hospice Nurse Aide 12 turned the corner and started down the hall to the resident's room, Nurse Aide 13 called out to Hospice Nurse Aide 12, She needs foot rests, she needs foot rests. Nurse Aide 13 got up from the desk and met Hospice Nurse Aide 12 at Resident 48's doorway and told her again that the resident needed to have foot rests in place on her wheelchair while being pushed. Hospice Nurse Aide 12 then went into the resident's room, opened her closet doors, and looked for the foot rests, which were in a bag attached to the back of the resident's wheelchair. Interview with Nurse Aide 13 on March 12, 2020, at 3:05 p.m. confirmed that Hospice Nurse Aide 12 should have had foot rests in place on Resident 48's wheelchair when pushing her. Interview with the Director of Nursing on March 10, 2020, at 4:12 p.m. confirmed that staff were to use foot rests when pushing residents in wheelchairs. 28 Pa. Code 211.10(d) Resident care policies. |
| F 0694<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide for the safe, appropriate administration of IV fluids for a resident when needed.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on review of facility policies and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that long-term intravenous catheters were flushed according to facility policy for one of 29 residents reviewed (Resident 35). Findings include: The facility's policy regarding peripherally inserted central catheters (PICC line - a catheter that is placed in a peripheral vein for long-term administration of fluids and/or medication), dated January 10, 2020, indicated that when infusing intermittent drugs or antibiotics, the procedure was to flush the catheter with normal saline solution (sterile salt and water solution), administer the medication, then flush afterward with normal saline. The policy did not include the amount of normal saline solution to use for flushing the catheter. physician's orders [REDACTED]. Resident 35's Medication Administration Record [REDACTED]. However, there was no documented evidence that staff flushed Resident 35's PICC line with normal saline solution before and after the administration of [MEDICATION NAME] on these days. Interview with the Director of Nursing on March 5, 2020, at 6:22 p.m. confirmed that there was no documented evidence that Resident 35's PICC line was flushed before and after the administration of [MEDICATION NAME]. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services. |
| F 0760<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that residents are free from significant medication errors.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on review of facility policies and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that it was free from significant medication errors for two of 29 residents reviewed (Residents 1, 110). Findings include: The facility's policy regarding medication administration, dated January 10, 2020, indicated that medications were to be administered as prescribed, in accordance with good nursing principles and practices, and only by persons legally authorized to do so. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs)for Resident 1, dated February 28, 2020, revealed that the resident was severely cognitively impaired, required extensive assistance from staff for toileting, and was always incontinent of bowel and bladder. physician's orders [REDACTED]. rectally to stimulate a bowel movement) as needed for constipation on day six without a bowel movement. Resident 1's bowel movement records revealed that she did not have a bowel movement from December 14 through 19, 2019, (six days) and the resident's nursing notes and Medication Administration Records (MAR's) for December 2019 revealed that staff administered 30 ml's of Milk of Magnesia on December 17, 2019, at 1:30 p.m. and a [MEDICATION NAME] suppository on December 18 at 1:55 p.m., without any results. There was no documented evidence that a Fleets enema was administered on December 19, 2019 (the sixth day without a bowel movement) as ordered by the physician. Interview with the Director of Nursing on March 12, 2020, at 12:58 p.m. confirmed that Resident 1's physician's orders [REDACTED]. physician's orders [REDACTED]. Resident 110's MAR's for March 2020 revealed that on March 4, 2020, prior to the meal the resident's blood sugar level was 280 mg/dL and 4 units of [MEDICATION NAME] was administered instead of 2 units as ordered. Interview with the Director of Nursing on March 12, 2020, at 12:58 p.m. confirmed that Resident 110's physician's orders [REDACTED]. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services. |
| F 0842<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record reviews and staff interviews, it was determined that the facility failed to maintain clinical records that were accurately documented for one of 39 residents reviewed (Resident 110). Findings include: A nursing note, dated March 5, 2020, at 11:45 p.m. revealed that Resident 110 had audible wheezing; decreased breath sounds; a harsh, congested non-productive cough; a temperature of 101.8 degrees Fahrenheit; and his color was pale. On March 6, 2020, at 12:15 a.m. the physician was notified and orders were received for a chest x-ray, a flu swab (test for influenza), and nebulizer treatments. A laboratory report, dated March 6, 2020, revealed that the resident tested positive for influenza [MEDICAL CONDITION], the physician was notified, and droplet precautions (special infection control procedures) were ordered. However, there was no documented evidence that the physcian's order to implement droplet precautions was entered into Resident 110's electronic medical record until March 9, 2020. Interview with the Director of Nursing on March 11, 2020, at 4:03 p.m. confirmed that staff did not enter the physician's orders [REDACTED]. 28 Pa. Code 211.5(f) Clinical records. |
| F 0867<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Set up an ongoing quality assessment and assurance group to review quality deficiencies** |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0867<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 3)<br>**and develop corrective plans of action.**<br><br>Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to ensure that corrective plans to improve and/or correct quality deficiencies effectively addressed recurring deficiencies and ensured that the facility maintained compliance with nursing home regulations. Findings include: The facility's deficiencies and plans of correction for State Survey and Certification (Department of Health) surveys ending March 14 and September 3, 2019, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending March 12, 2020, identified repeated deficiencies related to professional standards of practice and failure to be free from significant medication errors. The facility's plan of correction for a deficiency regarding meeting professional standards of quality, cited during the survey ending September 3, 2019, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F658, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding following professional standards of quality. The facility's plan of correction for a deficiency regarding failure to be free from significant medication errors, cited during the survey ending March 14, 2019, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F760, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding residents being free from significant medication errors. Refer to F658, F760. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. |