STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395395	A. BUILDING _____ B. WING _____	**08/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLONIAL PARK CARE CENTER	**800 KING RUSS ROAD HARRISBURG, PA 17109**

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 observations, review of clinical records and staff interviews, it was determined that the facility failed to accommodate the resident's needs by failing to ensure that call bells were within reach for one of ten residents observed (Resident 3). Findings include: Review of Resident 3's physician orders [REDACTED]. [MEDICAL CONDITION] is a severe or complete loss of strength). During an interview with Resident 3 in his room on August 25, 2020, at approximately 12:00 PM, it was observed that Resident 3 was seated in his specialty chair, aligned alongside his bed approximately at the midpoint, with the back to the wall. It was also observed that his call light was pinned to his pillow at the head of his bed behind him. When Resident 3 was questioned as to whether he would be able to reach it, he answered no. During an interview with Resident 3 in his room on August 26, 2020, at 1:00 PM, it was observed that Resident 3 was seated in his specialty chair, aligned alongside his bed approximately at the midpoint, with the back to the wall. It was also observed that his call light was not observable and Resident stated he didn't know where it was. Registered Nurse (RN) 1 was brought back to Resident 3's room and discovered the call light wedged down between the bed and his chair. RN 1 revealed that his call light is usually pinned close to him, at which time she discovered that the pin was not on the call light. RN 1 revealed the expectation that his call light should have been accessible. During an interview with the Nursing Home Administrator (NHA), on August 26, 2020, at approximately 3:35 PM, the NHA revealed the expectation that Resident 3's call light should have been accessible. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and select facility documents and staff interview, it was determined that the facility failed to notify resident's representative of a change in condition for one of six residents reviewed. (Resident R1.) Findings include: Review of Resident 1's clinical record revealed [DIAGNOSES REDACTED]., judgment, cognition, learning, and, eventually, ability to function). Review of Resident 1's clinical record revealed that Resident 1 had had a fall with head injury on July 17, 2020, and that facility nursing staff had contacted the POA to inform her of Resident 1's fall and transfer out of the facility to an emergency room . Review of Resident 1's clinical records revealed the nursing note dated for July 17, 2020, at 9:14 PM which stated Resident's (name-POA) notified and would like a call upon resident's return. Further review of Resident 1's clinical record revealed a nursing progress note dated for July 18, 2020, at 5:05 AM which revealed that the resident had returned to facility and did not need any stitches for her scalp laceration and that a chest x-ray was positive for a right pleural effusion (a buildup of fluid in the pleural space, an area between the layers of tissue that line the lungs and the chest wall). Further review of Resident 1's clinical record failed to reveal documentation that Resident 1's POA was notified regarding Resident 1's return to the facility, status or room change. Nursing Home Administrator (NHA) was asked as to whether there was documentation of Resident 1's POA being called back and notified of Resident 1's condition following her transfer out toER on [DATE]. NHA responded via E-mail on August 28, 2020, at 12:36 PM that We cannot find that the POA was called Saturday morning per request. During an interview with NHA on August 28, 2020, via telephone at approximately 3:40 PM, the NHA revealed the expectation that the POA would have been called back. 28 Pa. Code: 211.12(d)(1)(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.