STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395610	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHLAND HEALTHCARE AND REHABILITATION CENTER	349 VOTECH DRIVE JOHNSTOWN, PA 15904

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 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 resident and staff interviews, it was determined that the facility failed to maintain each resident's dignity by answering call bells timely for one of 10 residents reviewed (Resident 8). Findings include: The facility's policy regarding answering residents' call bells, dated October 10, 2019, indicated that staff were to answer residents' call lights as soon as possible, if they promised the resident they would return with requested items they were to do so promptly, and if assistance was needed when a staff member entered the room, the staff member was to summon help by using the call bell. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated June 8, 2020, indicated that the resident was able to understand and be understood, required extensive assistance from one to two staff for hygiene and toileting, was always continent of bowel and bladder, and had [DIAGNOSES REDACTED]. The resident's care plan, dated July 18, 2019, revealed that he require the use of a sit-to-stand mechanical lift (device that uses hydraulic power to lift and transfer a person from surface to surface) and the assistance of two staff for transfers. The resident's bowel continence records for May 1 through July 6, 2020, revealed that the resident was incontinent of bowel one time in 67 days. Observations on July 6, 2020, at 1:45 p.m. revealed that Resident 8 had activated his call bell, and when questioned by the surveyor regarding why he was ringing, the resident responded emphatically, Because I s**t myself! I rang at 12:30 (p.m.) to go to the bathroom and the aide told me she needed to go find another staff to help her and never came back. I rang again and a different aide came in and told me the same thing. I couldn't hold it anymore, and now I need cleaned up. My ride to [MEDICAL TREATMENT] (a procedure that filters toxins out of a person's blood when their kidneys no longer function properly) will be here at 2:00 p.m. and if I'm not cleaned up and ready to go they won't take me! I don't want to miss my [MEDICAL TREATMENT] treatment because it will be Wednesday before I can get another one. Nurse Aides 3 and 4 entered the room at 1:50 p.m. and asked the resident what he needed. Resident 8 told them the story of how he rang his bell earlier because he needed to move his bowels and was told they would come back but they did not, the third time he rang he had soiled himself while waiting, and he was upset and worried that he might miss his [MEDICAL TREATMENT] appointment. Observations on July 6, 2020, at 1:54 p.m. revealed that Nurse Aides 3 and 4 assisted Resident 8 to the bathroom using a sit-to-stand mechanical lift. The resident had been incontinent of a moderate amount of soft, brown stool and his sweat pants were soiled. The nurse aides cleaned the resident and dressed him in a fresh pair of sweat pants. Interviews with Nurse Aides 3 and 4 on July 6, 2020, at 2:00 p.m. confirmed that they had both individually answered Resident 8's call bell earlier, Nurse Aide 3 around 12:30 p.m. and Nurse Aide 4 sometime after that (she could not recall the exact time). Both explained that it was during meal time and that there were no other staff present on the unit to help them use the sit-to-stand lift. Interview with the Director of Nursing on June 7, 2020, at 11:55 a.m. revealed that staff should have found another available staff member (even if they had to leave their assigned unit) upon Resident 8's first request to be toileted. 28 Pa. Code 201.29(j) Resident rights. 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.** Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to notify the resident's responsible party in a timely manner following a change in condition for one of 10 residents reviewed (Resident 3). Findings include: The facility's policy regarding changes in a resident's condition, dated October 10, 2019, indicated that the facility was to promptly notify the resident and his/her representative about changes in the resident's condition, care and/or status. Nursing notes for Resident 3, dated April 22 through 27, 2020, indicated that the resident's skin was warm, dry and intact. Wound evaluation forms dated April 19 and 23, 2020, revealed that the resident had red, moist, excoriated areas located bilaterally on her inner buttocks and staff were to apply a protective barrier cream twice daily. On April 27, 2020, the wound evaluation forms indicated that the red, moist, excoriated areas had now become open, measuring 1.0 x 0.4 x 0.1 (unit not specified) and a new treatment and protective dressing was to be applied every other day. There was no documented evidence that Resident 3's representative was notified about the excoriated area becoming open or that a new treatment was being applied. Interview with the Director of Nursing on July 7, 2020, at 7:10 p.m. confirmed that there was no documented evidence that Resident 3's representative was notified about the excoriated area on the inner buttocks becoming open and being treated with a new treatment. She confirmed that the resident's representative should have been called. 28 Pa. Code 211.12(d)(1)(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 clinical record reviews, observations, and interviews with residents and staff, it was determined that the facility failed to maintain a comfortable and homelike environment, by failing to ensure that bed linens were clean for one of 10 residents reviewed (Resident 1). Findings include: A comprehensive significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated May 15, 2020, revealed that the resident had severe cognitive impairment and required extensive assistance from staff for daily care tasks. Observations of Resident 1 while in his bed on July 6, 2020, during day shift at 12:00 p.m. and 1:35 p.m., and during the evening shift at 2:43 p.m. revealed that the draw sheet (middle sheet used to help with repositioning) had three large, dried, dark brown stains that were approximately one inch in diameter, each near the resident's thigh and knee. The resident noticed the stains and said, Oh my, I must have dirtied myself, will you please help me? Interviews with Nurse Aides 1 and 2 on July 6, 2020, at 2:43 p.m. confirmed that Resident 1's linens were soiled and should have been changed. They immediately performed incontinent care for the resident and noted that he was not soiled and that the stains must have been from earlier. Interview with the Director of Nursing on July 6, 2020, at 3:55 p.m. confirmed that linens are to be changed when soiled and that Resident 1's linens should have been changed by the staff on the day shift. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and**

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
	395610	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHLAND HEALTHCARE AND REHABILITATION CENTER	349 VOTECH DRIVE JOHNSTOWN, PA 15904

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **prepared, reviewed, and revised by a team of health professionals.** **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 review and revise care plans for two of 10 residents reviewed (Residents 1, 4). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated May 15, 2020, revealed that the resident was severely cognitively impaired and required extensive assistance for daily care tasks. The resident's care plan, dated February 10, 2019, revealed that he did not want showers and preferred to get bathed at the bedside. Current nurse aide documentation indicated that the resident preferred a shower during the evening shift times a week. There was no evidence that the care plan was updated with Resident 1's current bathing preferences. An annual MDS assessment for Resident 4, dated May 20, 2020, revealed that the resident was cognitively impaired, very hard of hearing, and required extensive assistance for daily care tasks. physician's orders [REDACTED]. Observations of Resident 4 on July 7, 2020, at 11:45 a.m. revealed that she was in bed and an activity aide was at her bedside. Resident 4 had a hearing aid in both of her ears. There was no evidence that the resident's care plan was updated to include that she used bilateral hearing aids. Interview with the Director of Nursing on July 7, 2020, at 2:45 p.m. confirmed that the care plans should have been updated with Resident 1's shower preferences and Resident 4's hearing aids. 28 Pa. Code 211.11(a)(d) Resident care plan.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** Based on review of the Pennsylvania Nursing Practice Act and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a professional (registered) nurse assessed a change in the condition of a wound for one of 10 residents reviewed (Resident 3). 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, and was responsible for assessing human responses and plans, implementing nursing care, and analyzing/comparing data with the norm in determining care needs. Nursing notes for Resident 3, dated April 22 through 27, 2020, indicated that the resident's skin was warm, dry and intact. Wound evaluation forms dated April 19 and 23, 2020, revealed that the resident had red, moist, excoriated areas located bilaterally on her inner buttocks and staff were to apply a protective barrier cream twice daily. On April 27, 2020, the wound evaluation forms (authored by a licensed practical nurse) indicated that the red, moist, excoriated areas had now become open, measuring 1.0 x 0.4 x 0.1 (unit not specified), and a new treatment and protective dressing were to be applied every other day. There was no documented evidence that Resident 3's open wound was assessed by a professional (registered) nurse. Interview with the Director of Nursing on July 7, 2020, at 7:10 p.m. confirmed that there was no documented evidence that Resident 3's open area on the inner buttocks was assessed by a registered nurse and it should have been. 28 Pa. Code 211.12(d)(1)(5) Nursing services.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that residents were provided with showers as scheduled for four of 10 residents reviewed (Residents 4, 5, 9, 10). Findings include: A comprehensive annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated May 20, 2020, indicated that the resident was cognitively impaired and was dependent on staff for bathing. Bathing documentation for April 1 through July 3, 2020, indicated that the resident was to receive showers during the day shift (6:00 a.m. to 2:00 p.m.) on Tuesdays and Fridays. However there was no documented evidence that the resident received a shower as scheduled on Tuesdays and Fridays, April 21, 24 and 28; May 1, 5, 8, 12, 15, 19, 22, 26 and 29; and June 2, 5, 9, 12, 16, 23, 26 and 30, 2020. There was no documented evidence that the showers were offered and refused by the resident. A quarterly MDS assessment for Resident 5, dated May 4, 2020, indicated that the resident was alert and oriented, dependent for bathing, and had [DIAGNOSES REDACTED]. The resident's care plan, dated April 29, 2020, indicated that the resident's preference was to be showered during the evening on Mondays and Thursdays. Bathing documentation for April 1 through July 6, 2020, indicated that the resident was to receive showers during the evening shift (2:00 p.m. to 10:00 p.m.) on Mondays and Thursdays. However there was no documented evidence that the resident received a shower as scheduled on Mondays and Thursdays, April 2, 13, 15, 19, 22, 27 and 30; May 4, 7, 8, 11, 14 and 18; June 29; and July 2 and 7, 2020. There was no documented evidence that the showers were offered and refused by the resident. A comprehensive annual MDS assessment for Resident 9, dated June 2, 2020, indicated that the resident was cognitively impaired, dependent for bathing, and had [DIAGNOSES REDACTED]. However, there was no documented evidence that Resident 9 received either a bath or a shower as scheduled on Tuesdays and Fridays, May 1 and 29; June 5, 12, 16 and 30; and July 3, 2020. There was no documented evidence that the showers were offered and refused by the resident. A quarterly MDS assessment for Resident 10, dated June 16, 2020, indicated that the resident was alert and oriented and dependent for bathing. Bathing documentation for May 1 through July 3, 2020, indicated that the resident was to receive showers during the evening shift on Mondays and Thursdays. However there was no documented evidence that the resident received a bath or shower as scheduled on May 2, 6, 13 and 27, 2020, and the resident received bed baths instead of showers on May 11, 16, 20, 25 and 30, 2020. A grievance report, dated June 15, 2020, revealed that Resident 10 indicated that he had not received a shower since moving off the B wing of the facility, and he wanted showers and not bed baths. The grievance form indicated that the resident's care plan would be updated to include the resident's preference to have evening showers on Mondays and Thursdays. However, review of shower documentation for June and July 2020 revealed that Resident 10 received bed baths and not showers on Mondays and Thursdays, June 3, 10, 13, 17, 20 and 24; and July 1, 2020. Interview with the Director of Nursing and Nursing Home Administrator on July 7, 2020, at 5:30 p.m. confirmed that there was no documented evidence that the above residents received showers as scheduled and they should have. They indicated that the state epidemiologist had previously instructed them not to take residents off their unit to shower on another wing; however, Resident 10 had a communal shower room located on his unit. 28 Pa. Code 211.12(d)(5) Nursing services.
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 reviews, observations and 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: A comprehensive annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated June 2, 2020, indicated that the resident was cognitively impaired, required extensive assistance to perform daily care tasks, was dependent for bathing, and had [DIAGNOSES REDACTED]. The resident's current care plan, initiated December 28, 2017, included an intervention to keep the resident clean and well groomed daily to promote dignity and psychosocial well being. physician's orders [REDACTED]. Treatment Administration Records (TAR's) for May, June and July 2020 revealed no documented evidence that T-Gel shampoo was used at any time during this three-month period. The resident's bathing/shower records revealed that the resident received bed baths, and did not receive showers, during May, June and July 2020. Observations on July 6, 2020, at 11:00 a.m revealed that Resident 9 was lying in bed. Her hair was sticking up on the top of her head and was flattened down in the back where it had been against the pillow. At the top of her forehead, extending into and beyond her hairline approximately one-half inch, was a patch (approximately 1.5 x 0.5 inches) of what appeared to be thickened, built-up dead skin flakes. The resident also had similar areas of built-up, flaky dead skin above each of her ears in the hairline. These areas were still present and unchanged during observations on July 6, 2020, at 2:00 p.m. and July 7, 2020, at 11:00 a.m. Interview with Nurse Aide 3 on July 6, 2020, at 1:50 p.m. confirmed that Resident 9 had a build-up of skin debris on her scalp. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395610	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHLAND HEALTHCARE AND REHABILITATION CENTER	**349 VOTECH DRIVE JOHNSTOWN, PA 15904**

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	(continued... from page 2) indicated that the T-gel shampoo was kept in the treatment cart and the nurse aides had to ask the licensed practical nurses to get it out for them when they were taking the resident for a shower. Interview with Licensed Practical Nurse 5 on July 7, 2020, at 2:00 p.m. confirmed that nurse aides were to ask the licensed nurses for the T-Gel shampoo from the treatment cart on Resident 9's shower days. She confirmed that Resident 9's hair needed washed. Interview with the Director of Nursing on July 7, 2020, at 3:00 p.m. revealed that the application and use of T-Gel shampoo was to be documented on Resident 9's TAR's, but there was no documentation on the TAR's to show that is was used during May, June and July 2020. 28 Pa. Code 211.12(d)(1)(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 review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper hand washing/hand hygiene was completed and infection control practices were maintained during and after incontinent care for one of 10 residents reviewed (Resident 9). Findings include: The facility's policy regarding hand washing/hand hygiene, dated October 10, 2019, revealed that hand hygiene was to be performed before moving from a contaminated body site to a clean body site during resident care, after contact with body fluids, and after handling used dressings or contaminated equipment, etc. A comprehensive annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated June 2, 2020, indicated that the resident was severely cognitively impaired, required extensive assistance from staff for daily care tasks, was occasionally incontinent of bowel, and was frequently incontinent of bladder. Observations during incontinent care for Resident 9 on July 6, 2020, at 1:20 p.m. revealed that with gloves on, Nurse Aide 6 cleaned a large amount of stool from the resident's buttocks, and then rolled the soiled incontinent brief and tucked it under the resident's buttocks. With the same gloves on, the nurse aide obtained a clean brief, opened it up, and laid it on the bed. Nurse Aide 6 then opened the resident's bedside drawer, obtained a tube of barrier/skin protectant cream, opened the tube, squeezed a dollop of the cream onto her gloved hand, and applied the cream to the resident's buttocks. With the same gloves on, she then positioned and secured the new brief, assisted the physical therapist to put a pair of pants on the resident, and assisted the resident to transfer to her chair using a sit-to-stand mechanical lift (device that uses hydraulic power to lift and transfer a person while in a standing position). Prior to moving the wheelchair into position, Nurse Aide 6 took the wheelchair foot rests off the chair and laid them directly on top of an anti-slip place mat (used for meals) located on the resident's overbed table. With the same gloves on, the nurse aide placed her hands on the arm of the resident's sweater, the back of her uncovered right hand, and also on the handles of the mechanical lift. Nurse Aide 6 and the therapist assisted the resident into her wheelchair and applied the foot rests to the chair. It was not until after Nurse Aide 6 handed Resident 9 her call bell and placed two boxes of tissues on the overbed table, that she removed her gloves and washed her hands. Interview with Nurse Aide 6 on June 6, 2020, at 1:40 p.m. confirmed that she did not remove her gloves after cleaning stool from the resident's buttocks, and she proceeded to touch many surfaces and items with her used gloves. She indicated that she was taught that she did not need to change her gloves unless they were visibly soiled. Interview with the Director of Nursing on July 6, 2020, at 12:07 p.m. confirmed that Nurse Aide 6 should have removed her gloves and washed her hands with soap and water after cleaning the stool and prior to applying the barrier cream to the residents buttocks or touching any other items in the room. She also confirmed that the foot rests should not have been placed on top of the non-skid place mat that was intended to keep the resident's dinnerware and utensils in place during meals. 28 Pa. Code 211.12(d)(1)(5) Nursing services.