STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395142	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDENS AT BLUE RIDGE, THE	**3625 NORTH PROGRESS AVE HARRISBURG, PA 17110**

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 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, review of Resident grievances, and staff interview, it was determined that the facility failed to resolve grievances and failed to notify the Residents of any corrective action taken to resolve the grievance for 6 of 9 Residents reviewed (Residents 2, 3, 4, 5, 6 and 7). Findings Include: Review of the facility's current Grievance Policy revealed that the facility has a system in place to ensure the residents right to prompt efforts to resolve grievances that they may have. The grievance official shall oversee the grievance process, lead necessary investigations, take immediate action to prevent further potential violations of a resident's right, report all alleged violations involving neglect, abuse and injuries of unknown source and take appropriate corrective action in accordance with state law. Review of Resident 2's clinical record revealed [DIAGNOSES REDACTED]. Review of a grievance filed by Resident 2, dated June 24, 2020, revealed that per Resident 2, she was placed on the bed pan by third shift staff on the night of June 23, 2020. Resident 2 stated she was left on the bed pan for an hour and a half, had hit the call light shortly after being put on it but no one came. Resident also stated a concern in this grievance about her nebulizer mask. Review of the grievance under Steps taken to investigate the grievance/Departments involved revealed interviewed staff and RN (registered nurse) shift supervisor. Under the section on the grievance Summary of the pertinent findings or conclusions regarding the resident's concern(s): revealed the nebulizer mask concern was addressed but there was no mention of Resident's concern about being left on the bed pan. Further review of the grievance revealed a resolution date was documented as being June 24, 2020, with the question Resident/Responsible party satisfied with resolution with a box to check yes or no. Neither box was checked. No staff interviews were attached to the grievance. During a phone interview with the Director of Nursing on August 5, 2020, at approximately 4:10 PM he stated that he interviewed the staff about the bed pan incident but he has no documentation of any of the investigation that he did. During an additional interview with the DON on August 7, 2020, at 8:14 AM he stated that Resident can put herself on and off the bedpan. Review of Resident's current care plan revealed that she requires two person assist to turn and reposition in bed, with a revision date of May 4, 2020. Further review of Resident's care plan revealed The resident needs prompt response to all requests for assistance with a revision date of January 23, 2020. On June 16, 2020, Resident 3 filed a grievance that stated she had a bowel movement and notified staff at 11:00 AM but did not get changed until after lunch. When staff answered her call light, she was told that she would not be changed until after lunch. The grievance form stated that the steps taken to investigate involved review of charting and interviewed staff. The summary of findings stated that the resident was changed by the nurse aid after being told by the Registered Nurse supervisor to do so. During an interview with the Director of Nursing (DON) on August 6, 2020 at 11:55 AM he stated that the nurse aid was from an agency and no longer works at the facility. He expressed that it was lunch time and they do the best they can. When the surveyor asked for additional information and timeline of evens the DON stated it was almost two months ago and he can't recall all the events. The Nursing Home Administrator confirmed that there should have been written statements from staff and more documented. The grievance form concluded that Resident 3's grievance was not confirmed. The corrective action included that the Nurse aid responsible was agency and is no longer allowed to return to the facility. The investigation did not include any statements from staff or any additional information. Resident 4 filed a grievance on June 22, 2020. The grievance stated that she laid in her urine for 3 hours because no one came to answer her call bell. The steps taken to investigate noted that the social services coordinator notified the nurse aid and nurse that the resident needed changed. Staff were interviewed and the resident is on hourly checks to assure resident needs are being met. The summary of findings stated that the DON and member from Area Aging Agency will have weekly calls to assure that all items are addressed in a timely manner. The facility determined that the grievance was not confirmed. No further action was taken. Surveyor requested documentation on 1 hour checks. An interview with the DON on August 6, 2020 at 12:05 PM he stated that the resident makes false accusations and that staff do not document every hour that they checked on the resident. There was no care plan for Resident 4 regarding making false accusations. The facility was unable to provide further documentation regarding the allegation. A grievance was filed on June 23, 2020 on behalf of Resident 5. Facility staff member came to Resident 5's room for therapy and found him to be saturated in urine through the brief, two sheets and to the mattress. The steps taken to investigate stated that the resident's careplan and ADL's were reviewed. The summary of findings stated that the resident is saturated at times when the external catheter is displaced. Staff provide ADL care to resident before appointments/ therapy. There was nothing documented that the grievance was confirmed or not confirmed, and the action taken by the facility was not completed. The resident/responsible party satisfied with resolution section was also not completed. The facility did not provide any additional information regarding resolution to the grievance or any further investigation. Further review of grievances revealed a grievance filed by Resident 6 on June 23, 2020. Resident 6 stated that her roommate, Resident 9, was not provided care until 12:00 PM. Resident 6 activated the call light and no one came for 2 hours. Resident 6 stated that the nurse aid would walk by but not come in. Resident 6 alleged that when the nurse aid did come in the room, she asked the housekeeper to help with care but the housekeeper refused. The summary of findings was that the ADL documentation was reviewed and staff who worked that day were interviewed and did not recall the incident. The grievance was determined to be not confirmed, there was not follow up action and the resident/responsible party satisfied with resolution was left blank. The facility did not provide any additional information into the investigation of the grievance. Resident 7 filed a grievance on June 23, 3030 stating that the call light was activated on Friday June 19, 2020 at 1:20 PM because he was incontinent of bowel. The resident waited 30 minutes, and no one came. He then called the facility phone number to tell the nurses station that he needed incontinence care but there was no answer. The resident stated that no one answered the call light until 4:10 PM. The steps taken to investigate included interviews with staff and review of ADL documentation. The summary of findings stated that staff were completing rounds and all residents were toileted and cleaned. The grievance was determined to be not confirmed, there was not follow up action and the resident/responsible party satisfied with resolution was left blank. The facility was unable to provide further investigation into the allegation. During an interview with the DON on August 6, 2020 at 12:10 PM he stated that because the staff perform rounds that the resident was changed. There were no statements obtained or evidence of further investigation into the event. 28 Pa. Code 201.29(a) Resident rights.
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.** **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 care and services were provided in accordance with professional standards for one of nine residents reviewed (Resident 2). Findings Include: Review of Resident 2's clinical record revealed [DIAGNOSES REDACTED]. Review of Resident 2's physician orders [REDACTED].

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 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Further review of Resident 2's physician orders [REDACTED]. Review of Resident 2's Medication Administration Record [REDACTED]. Review of corresponding progress note on June 14 at 8:00 PM revealed that the medication was not available. Review of corresponding progress notes on June 15 at 12:00 AM, 4:00 AM and 12:00 PM revealed that a new prescription was needed. Review of corresponding progress note on June 15 at 8:00 AM revealed no reason was given as to why the medication was held. Further review of the corresponding progress note on June 15, at 12:00 AM revealed that Tylenol was given. Review of Resident 2's June MAR failed to reveal any documentation that Tylenol was given at that time. Further review of Resident 2's June MAR indicated [REDACTED]. There is no evidence in Resident 2's clinical record that the physician was made aware that Resident 2 did not receive her [MEDICATION NAME]-[MEDICATION NAME] for five consecutive doses. During an interview with the Director of Nursing (DON) on August 7, 2020, at approximately 8:20 AM he stated that the facility has that medication in their Pyxis (medication dispensing system) but it was an agency nurse working and agency staff do not have access. He stated the physician would have had to been made aware since a new prescription was needed but he confirmed that there was no documentation of the physician being made aware. 28 Pa. Code 211.12(d)(1)(5) Nursing services.