STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395571	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MUNCY PLACE	**215 EAST WATER STREET MUNCY, PA 17756**

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 -** Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policies, review of facility documentation, and resident and staff interview, it was determined that the facility failed to accommodate resident needs regarding call bells for residents residing on the First and Second floors and four of 24 residents reviewed (Residents 113, 105, 29, and 35). Findings include: The policy entitled Call Bell Response and Call System Failure (Resident), last reviewed on February 12, 2020, revealed staff are to respond to the resident's need and turn off the call bell unless further assistance is needed. If the staff member responding to the bell cannot provide the needed assistance, the call bell is left activated and the staff person will go find another staff member that can meet the resident's need. The call bell should be answered promptly. Review of the Resident Council/Call Bell Committee Meeting minutes for December 2019, and January and February 2020 revealed residents voiced concerns regarding call bells during the December 12, 2019, and January 9, 2020 meetings. The surveyor conducted a resident group interview with 11 residents on March 3, 2020. The residents stated that call bells are not answered timely. The residents stated it can take 30 to 45 minutes for staff to meet their needs. The residents stated that staff will come into the room and turn off the call bell without meeting their needs. Resident 35 stated that she has waited hours for staff assistance, especially after meals. Resident 105 (Resident 35's roommate) stated that she has witnessed Resident 35 waiting for over 30 minutes for staff assistance. Resident 29 stated that she has waited 30 minutes for staff to meet her needs. Interview with the Nursing Home Administrator on March 4, 2020, at 10:20 AM confirmed that the call bell system (badges) deactivate the call bell when the staff enters the resident room, even if the resident need has not been met. The Nursing Home Administrator confirmed that the times on the call bell reports have the potential to be inaccurate due to the system deactivating when staff enter a resident room. She stated it is the expectation that staff meet resident needs within 15 minutes. A random review of the facility's automated call bell report (a report that indicated the time the call bell is activated, until the time a staff member enters the resident room) for February 1 to March 3, 2020 revealed the following: The resident room shared by Residents 35 and 105 had 45 call bell activations [MEDICATION NAME] more than 16 minutes with the longest being an hour and 50 minutes on February 10, 2020. Resident 29's room had 10 call bell activations [MEDICATION NAME] more than 16 minutes with the longest being over 57 minutes on February 9, 2020. Interview with Resident 113 on March 2, 2020, at 11:20 AM revealed concerns that staff do not answer her call bell timely. She stated that she has waited for 30 minutes to an hour for staff assistance. She stated that staff turn her call bell off when they enter her room and frequently do not meet her needs. She stated that staff will not come back for 30-45 minutes after they deactivated her call bell. Review of Resident 113's call bell report for February 1 to March 4, 2020 revealed 28 call bell activations [MEDICATION NAME] more than 16 minutes with the longest being 48 minutes. The surveyor reviewed the above findings during an interview with the Nursing Home Administrator on March 5, 2020, at 8:55 AM. 28 Pa. Code 211.12(d)(5) Nursing services
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on review of select facility policies and procedures, employee personnel records, and staff interview, it was determined that the facility failed to develop and implement an abuse prohibition policy that required a thorough investigation of prospective employee's employment history for one of five newly hired employees reviewed (Employees 4). Findings include: The policy entitled Abuse: Prevention, Investigation, and Reporting, last reviewed without changes on February 12, 2020, revealed the facility will screen potential employees by completing criminal background and reference checks according to human resource policy. Review of Employee 4's (service assistant) personnel record revealed that the facility hired him on November 4, 2019. Employee 4's personnel record did not reveal any evidence that a facility representative attempted to obtain information from a former employer and/or current employer. Interview with Employee 6 (human resource) on March 5, 2020, at 10:00 AM confirmed reference checks were not completed on Employee 4. He stated that it is the facility policy to only obtain reference checks on licensed employees. 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.19 Personnel policies and procedures
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 prepared, reviewed, and revised by a team of health professionals.** Based on review of select facility policies and procedures, clinical record review, and resident and staff interview, it was determined that the facility failed to ensure that, to the extent practicable, a comprehensive care plan included the participation of the resident for one of two residents reviewed for participation in care planning concerns (Resident 7). Findings include: The facility policy entitled, Interdisciplinary Team Care Conference, last reviewed without changes on February 12, 2020, revealed that residents, when able, and/or their representatives are encouraged to participate in the care planning process. This would include attending the interdisciplinary meetings and revision to the plan of care per their wishes. Residents and/or representatives will be notified in writing of the meeting and invited to attend. If unable to attend the scheduled meeting, accommodations will be made to meet the resident and/or family at their convenience if they desire. In limited circumstances, the inclusion of the resident and/or representative may not be practicable (i.e. if resident is severely cognitively impaired or if resident's representative does not respond to facility attempts to contact). In these cases, documentation of the reasons, including steps the facility took to include the resident and/or resident representative, must be included in the medical record. Clinical record review for Resident 7 revealed an admission MDS assessment (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated September 11, 2019, that assessed Resident 7 as having adequate hearing for conversation, clear speech, is understood by and understands others, had a BIMS (Brief Interview for Mental Status, a portion of the assessment used to determine cognition status; a score of 13 through 15 is considered cognitively intact, a score of eight through 12 is considered moderately impaired, and a score of zero through seven is considered severely impaired) score of 15 (cognitively intact), and was able to complete an interview to obtain daily and activity preferences (such as how important it was to her to choose what clothes to wear, choices regarding bathing options, to choose her own bedtime, and to do her favorite activities, etc.). Quarterly MDS assessments dated October 2, 2019, and November 27, 2019, continued to assess Resident 7 as having adequate hearing, clear speech, was understood by and understood others, had a BIMS score of 13 (cognitively intact), and had no evidence of an acute change in mental status from her baseline. Interview with Resident 7 on March 2, 2020, at 11:41 AM revealed that she had not participated in her care plan meetings. Resident 7 claimed that she does not get an invitation to the care plan meeting; and that her sons do not come to meetings. Care conference documentation dated December 4, 2019, revealed that the facility sent an invitation letter and made a reminder phone call to Resident 7's responsible party with no response; and that Resident 7 did not attend due to, cognition. Care conference documentation

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
	395571	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MUNCY PLACE	215 EAST WATER STREET MUNCY, PA 17756

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) dated February 26, 2020, revealed that the facility sent an invitation letter and made a reminder phone call to Resident 7's responsible party with no response; and that Resident 7 did not attend due to, cognition. The same documentation indicated Resident 7 had a BIMS score of 15 and was capable of independent activities such as word searches and crosswords. Interview with the Nursing Home Administrator and Director of Nursing on March 4, 2020, at 2:30 PM failed to provide evidence that Resident 7 was incapable of expressing her opinions or preferences; or documentation that Resident 7's participation was not practicable for the development of her care plan. The facility was unable to provide documentation in the resident's clinical record to explain the lack of participation based on her cognition status for her care plan meetings. 28 Pa. Code 211.11(e) Resident care plan 28 Pa. Code 211.12(d)(3) Nursing services
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 review of select facility policies and procedures, select manufacturers' instructions, observation, and staff interview, it was determined that the facility failed to administer medication according to acceptable standards of practice for one of two residents reviewed for medication administration (Resident 84). Findings include: The Commonwealth of Pennsylvania Code, Title 49. Professional and Vocational Standards, Department of State, Chapter 21. State Board of Nursing, 21.145(a)(b)(3) Functions of the LPN (licensed practical nurse) stipulated that the LPN is prepared to function as a member of the health-care team by exercising sound nursing judgement based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation, of nursing care in settings where nursing takes place. The LPN administers medication and carries out the therapeutic treatment ordered for the patient in accordance with the following which includes: the LPN shall question any order which is perceived as unsafe or contraindicated for the patient or which is not clear and shall raise the issue with the ordering practitioner. If the ordering practitioner is not available, the LPN shall raise the issue with a registered nurse or other responsible person in a manner consistent with the protocols or policies of the facility. The BD AutoShield Duo (safety disposable needle utilized on pen injector devices for the injection of medications) Instructions for Use (obtained from the facility's second floor medication room) stipulated that the first step of attaching the needle to the pen includes that the user is to check if the pen needle is attached correctly by dialing two units (of the medication), point the pen up, and press the thumb button. If liquid does not appear at the needle tip, the user is instructed to repeat the step as recommended by the pen instructions. The second step instructs the user to dial the prescribed dose of medication on the pen. The [MEDICATION NAME] (pen-shaped device that uses a small thin needle, dial-a-dose with large print, and push button injection method to administer the hormone, insulin, to lower blood sugar) Instruction Leaflet (provided by the facility) stipulated that the user is to follow the instructions completely each time the user uses the [MEDICATION NAME] to ensure that the user gets an accurate dose. In bold print, the instructions stipulated that if the user did not follow the instructions, the user may get too much or too little insulin, which may affect blood glucose. Step two of the document instructs the user to attach a needle; and to always use a new sterile needle for each injection. Step three of the document instructs the user to always (the word always printed in bold and underlined) perform the safety test before each injection. Performing the safety test ensures that the user gets an accurate dose by ensuring that the pen and needle work properly and that the user removes all air bubbles. The user is instructed to select a dose of two units by turning the dosage selector, take off the outer and inner needle caps, and press the injection button all the way in. The user is instructed to check that insulin comes out of the needle tip. If no insulin is seen, the user is instructed to check for air bubbles and repeat the safety test two more times to remove them. If still no insulin comes out, the needle may be blocked. The user is instructed to change the needle and try again. If no insulin comes out after changing the needle, the [MEDICATION NAME] may be damaged. The user is instructed to not use that [MEDICATION NAME]. Step four of the procedure instructs the user to set the dose. Observation of a medication administration pass on March 4, 2020, at 8:48 AM revealed Employee 3 (licensed practical nurse) applied a new disposable needle (BD AutoShield Duo) to Resident 84's [MEDICATION NAME] (medication similar to the hormone, insulin, that occurs naturally in the body that helps control blood sugar) pen. Employee 3, then, dialed the physician prescribed unit dose of 1.8 milligrams (mg). Employee 3 continued to prepare Resident 84's medications and applied a new disposable needle (BD AutoShield Duo) to Resident 84's [MEDICATION NAME] pen. Employee 3 then dialed the initial 80 units of Resident 84's physician prescribed 95 units and stated that she would prepare the additional 15 units at Resident 84's bedside as the [MEDICATION NAME] pen had a maximum one-time dose of 80 units. Employee 3 entered Resident 84's room and administered the [MEDICATION NAME] medication via injection in Resident 84's left abdomen. Employee 3 then administered Resident 84's 80 units of [MEDICATION NAME] via injection on the right side of Resident 84's abdomen. Continued observation of the medication administration on March 4, 2020, at 8:58 AM revealed that Employee 3 removed the used needle from the [MEDICATION NAME] pen and applied a new disposable needle (BD AutoShield Duo). Employee 3 then dialed the remaining 15 units of Resident 84's prescribed dose of [MEDICATION NAME] and administered via injection in Resident 84's right abdomen. At no point did Employee 3 prime the BD AutoShield Duo needles before dialing the physician prescribed dose of medication during the above observations. Interview with Employee 3 on March 4, 2020, at 9:02 AM confirmed that she did not implement any procedure to prepare the pen needle before use. Employee 3 stated that she believed she was only required to do so when using an insulin pen for the first time; however, confirmed that she is to use a new disposable needle for each injection. The surveyor reviewed the above findings regarding the medication administration observation during an interview with the Nursing Home Administrator and Director of Nursing on March 4, 2020, at 2:30 PM. The facility policy entitled, Insulin Injection Administration Procedure, last reviewed without changes on February 12, 2020, revealed that staff are instructed to prime an insulin pen the first time of use and if days have elapsed without use. Interview with the Director of Nursing on March 5, 2020, at 10:05 AM confirmed that the facility policy did not include the required safety steps to prepare the disposable needle with each injection as stipulated in the disposable needle and medication product's instructions noted above. 483.21(b)(3)(i) Services Provided Meet Professional Standards Previously cited deficiency 1/8/20 28 Pa. Code 211.9(k) Pharmacy services 28 Pa. Code 211.10(a)(c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, and clinical record review, it was determined that the facility failed to ensure dependent residents received assistance with activities of daily living for one of three residents reviewed for vision concerns (Resident 91). Findings include: Clinical record review for Resident 91 revealed an admission MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) assessment dated [DATE], that assessed him as totally dependent on the assistance of staff for all activities of daily living; and that his [DIAGNOSES REDACTED]. Observation of Resident 91 on March 2, 2020, at 12:25 PM revealed that he was not wearing glasses. Interview with Resident 91 (completed primarily by his mouthing words and making gestures as he presented with a [MEDICAL CONDITION] (hole surgically placed through the front of the neck and into the windpipe to keep it open for breathing) rendering him unable to speak) revealed he gestured towards his bedside cabinet to indicate his glasses were located there; and he nodded affirmatively when asked if he was to wear the glasses routinely (not just for reading). Observation of Resident 91 on March 4, 2020, at 9:19 AM revealed him to not have glasses on. Resident 91 nodded affirmatively when asked if he wanted his glasses on. Interview with Employee 1 (nurse aide) on March 4, 2020, at 9:20 AM verified glasses found at Resident 91's bedside were his glasses and she placed them on Resident 91's face. Employee 1 stated that she was uncertain if Resident 1 always wore his glasses or if he adhered to any schedule for wearing them. Clinical record review for Resident 91 revealed no plan of care regarding Resident 91's use of glasses. Interview with the Nursing Home Administrator and Director of Nursing on March 4, 2020, at 2:30 PM revealed that the facility had no evidence of a plan of care or task assignment to alert nurse aid staff that Resident 91 wore glasses or their appropriate use. A plan of care created by the facility dated March 4, 2020, at 5:36 PM (following the surveyor's questioning), instructed staff to ensure Resident 91 was wearing his glasses when he voiced a preference to have them on. 28 Pa. Code 211.11(d) Resident care plan 28 Pa. Code 211.12(d)(1)(5) Nursing services
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395571	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MUNCY PLACE	**215 EAST WATER STREET MUNCY, PA 17756**

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) Based on observation and staff interview, it was determined that the facility failed to store, prepare, and serve food items in a safe and sanitary manner in the facility's main kitchen and on two of two nursing units (first and second floor). Findings include: Initial tour of the facility's main kitchen on March 2, 2020, at 8:45 AM with Employee 8 (dietary unit leader) revealed there was dust and dried food debris on the bottom shelves of two preparation tables, which contained boxes of potatoes, pan liners, and sheet trays. A large cart holding the Heat on Demand pellet heating system, as well as condiments, and plates, had dust and dried food on the shelves of the cart. French fries and other identified food items were present on the floor beside and under the cart. Employee 8 indicated these items were not served for breakfast that morning. A single door cooler in the preparation area with soup bases and containers of liquid eggs in it, contained a significant amount of debris on the bottom shelf of the cooler. The walk-in freezer had three piles of ice buildup on the floor underneath the freezer condenser unit. Ice buildup was present on the side freezer wall. The floor contained pieces of food in several areas in the freezer and under the shelving units. Concurrent observation of the first and second floor food service areas revealed the following: A refrigerator located in the kitchen in the first-floor dining area contained several dried spills, and debris on the shelves and bottom of the refrigerator. The seal to the refrigerator door had a build up of crumbs/debris. A steam table located in the kitchen had a thick brown/black buildup, as well as some dried food, in the basins of the steam table compartments. A steam stable located in the second-floor dining room food service area also contained a thick brown/black build up in the basins of the steam table compartments. A cabinet located under the sink in the second-floor dining area, contained multiple dried brown spots in the base of the cabinet. Employee 8 indicated she was not aware of any leaks from the pipes located in that cabinet. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on March 3, 2020, at 2:20 PM. 483.60 (i) Food, Store and Serve -Sanitary Previously cited deficiency 4/12/19 28 Pa. Code 211.6 (c)(d) Dietary 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 select policies and procedures, observation, and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection on one of two nursing units (Second Floor, Resident 91). Findings include: The facility policy entitled, Oxygen Delivery, last reviewed without changes on February 12, 2020, revealed that tubing for oxygen/nebulizers should be kept off the floor and in a plastic bag when not in use. The facility policy entitled, Care and Maintenance of Foley Catheters, last reviewed without changes on February 12, 2020, revealed that staff are instructed to keep the collection bag off the floor. Observation of Resident 91's room on March 2, 2020, at 12:26 PM revealed oxygen tubing extending from a supply outlet in the wall labeled, air, with an uncapped/unprotected hub end of the tubing laying directly on the floor. Interview with Employee 1 (nurse aide) on March 2, 2020, at 12:29 PM indicated that respiratory therapy would use that tubing to administer Resident 91's breathing treatments. Employee 1 removed and discarded the tubing. Observation of Resident 91's room on March 2, 2020, at 12:25 PM revealed he was in bed with the collection bag from his suprapubic catheter (tubing surgically placed through the skin of the lower abdomen into the bladder for the purpose of draining urine) covered by a pillowcase and laying directly on the floor. Interview with Employee 1 on March 2, 2020, at 12:29 PM confirmed that the urinary collection bag should not be resting directly on the floor. Employee 1 repositioned the bag to hang from Resident 91's bed frame. Interview with Employee 5, respiratory therapist, on March 2, 2020, at 12:52 PM confirmed that tubing from the yellow air supply would be used for Resident 91's respiratory treatments by the respiratory therapy department; and should not be laying on the floor. Observation of Resident 91's room with Employee 1 on March 4, 2020, at 9:19 AM revealed oxygen tubing extending from a portable oxygen tank next to Resident 91's bed with the other end of the tubing (equipped with a green tapered adapter) laying directly on the floor. Employee 1 removed the tubing for replacement. The facility failed to ensure that respiratory and urinary catheter equipment utilized for Resident 91 was stored in a manner to prevent the potential spread of infection. Observation of a medication administration cart on the second floor south hallway on March 5, 2020, at 11:54 AM with Employee 2 (licensed practical nurse) revealed that a bottom drawer of the medication cart contained a clear zippered sandwich bag without any labels containing crackers, loose disposable razors (Employee 2 was unable to state if the disposable razors were new or used, but confirmed they were not marked with any resident names), a bag of dental floss picks, and a 2020 Drug Handbook (nursing resource book for medication administration), stored with single use 10 ml (milliliters) prefilled syringes of 0.9 percent sodium chloride (normal sterile saline). Employee 2 disposed of the razors and food items. Interview with the Director of Nursing on March 5, 2020, at 1:00 PM revealed that it is the facility's expectation that staff do not store food and residents' personal care items with resident treatment products like sterile saline syringes. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control Previously cited deficiency 4/12/19 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services