STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395779	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTRE CREST	**502 EAST HOWARD STREET BELLEFONTE, PA 16823**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to provide care and services in a manner and in an environment that promotes residents' dignity for three of 35 residents reviewed (Residents 29, 107, and 141). Findings include: The Dignity Policy, last reviewed without changes on January 23, 2020, revealed that it is the policy of the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The policy included examples of promoting resident dignity as it pertains to their environment and private space, during dining, and in keeping residents sufficiently covered so as not to expose their bodies to others. Interview with Employee 4, nurse aide, on March 7, 2020, at 1:04 PM verified two meal carts arrived at the Keystone unit for meals for rooms 225 - 239 at approximately 11:59 AM. Observation of the Keystone Nursing Unit on March 9, 2020, at 11:54 AM, revealed a common lounge where three residents sat at a table. Two residents were eating their lunch meal while the third resident, identified by staff as Resident 107, was without any food. Interview with Employee 3, nurse aide, on March 9, 2020, at 11:55 AM confirmed Resident 107's food will arrive on the next food cart. Employee 3 confirmed that Resident 107 could not self-propel her chair to the lounge without staff assistance. Employee 3 removed Resident 107 from the table and out of the common lounge. The food cart containing Resident 107's tray arrived on March 9, 2020, at 12:09 PM, 15 minutes after the above observation. Interview with the Nursing Home Administrator, Director of Nursing, and Employee 1 (registered nurse assessment coordinator), on March 9, 2020, at 2:00 PM confirmed that the facility's expectation is that staff serve meals to all the residents seated at the same table at the same time. Observation of Resident 141's room on March 8, 2020, at 10:10 AM revealed he was in bed. The facility positioned Resident 141's bed so that the right side of his bed was against the wall, leaving the head of the bed facing an interior wall. Resident 141 could only look at a wall while he is in bed with this positioning. Nursing documentation dated March 9, 2020, at 5:33 PM revealed that since the surveyor brought up the concern, the facility moved Resident 141's bed back to its original positioning, leaving both sides of his bed open and with Resident 141 able to visualize his whole room, which included a large window to the outside. Observation on the Keystone Unit on March 8, 2020, at 8:41 AM revealed Resident 29 sitting on the edge of her bed eating breakfast in an adult brief. Resident 29 was visible from the hallway. When the surveyor went into Resident 29's room to talk with her, she pointed to her bare legs to show the surveyor and shrugged her shoulders and said, I don't know and shook her head. The surveyor reviewed the above findings related to Resident 29 during an interview with Employee 12, Interim Director of Nursing, on March 10, 2020, at 1:27 PM. 28 Pa. Code 201.29(j) Resident rights
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 review of facility policies, observation, and staff interview, it was determined that the facility failed to provide adequate housekeeping and maintenance services to ensure a clean, safe, and orderly environment on three of five nursing units (Laurel Circle, Klineway Nursing Units, and Stanton Court; Residents 153 and 104). Findings include: Review of the facility policy entitled Quality of Life - Homelike Environment, last reviewed on January 23, 2020, without changes, revealed that residents are provided with a safe, clean, comfortable, and homelike environment. Observation of Resident 153's room on the following dates and times revealed that is smelled strongly of urine: March 7, 2020, at 10:43 AM March 8, 2020, at 9:53 AM March 9, 2020, at 12:38 PM Observation of Resident 104's room on March 7, 2020, at 11:06 AM revealed that the drywall was marred by the head of her bed, the right side of the bed, and behind the bedside stand. The surveyor reviewed the above information during an interview with the Nursing Home Administrator on March 9, 2020, at 1:00 AM. Observation of the dining area on Stanton Court on March 7, 2020, at 11:10 AM revealed a plastic-like upholstered chair with exposed foam measuring approximately 16 centimeters, larger than the span of the surveyor's open hand. Another similar chair had a small tear exposing foam. Another similar chair had a tear exposing particle board at the base of the chair. Observation and interview with Employee 22, maintenance assistant, on March 8, 2020, at 11:30 AM revealed he removed the chairs from Stanton Court the day before. The surveyor reviewed the information about Stanton Court with the Nursing Home Administrator during an interview on March 8, 2020, at 1:30 PM. 483.10(i)(1)(i)(ii)(2) Safe/Clean/Comfortable/Homelike Environment Previously cited 5/3/19 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 207.2(a) Administrator's responsibility
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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.** Based on review of select facility policies and procedures, the facility's grievance history, observation, and resident and staff interview, it was determined that the facility failed to implement effective measures to resolve residents' grievances for one of two residents reviewed for dignity concerns (Resident 53), for four of nine residents who attended the group meeting (Residents 195, 165, 138 and 53), and for eight residents who submitted grievance concerns regarding staff response to call bells (Residents 99, 199, 195, 124, 203, 312, 190, and 313). Findings include: The facility's policy entitled, Resident and Family Grievance/Concern, last reviewed without changes on January 23, 2020, revealed that all aspects of the Grievance/Concern will be investigated by the appropriate department(s). This process should be treated with confidentiality, and utmost timeliness in response. It is expected that all action steps be taken timely, reported accordingly, and follow up provided. The social service team member, Director of Nursing, or Administrator will contact the family/representative/resident directly; explaining the results of the investigation and the action taken. All grievances will be reviewed monthly and monitored for trends. The facility's Call Bell Policy, last reviewed without changes on January 23, 2020, revealed that every resident living at the facility will have a means of communicating with staff from their room when they are in need of assistance. Every resident should have the peace of mind knowing that they can summon assistance regardless of their physical limitations. All call bells are a part of an electronic system that produces a signal at the nurse's station identifying the room number and causes a light to go on outside the resident's room. Enunciators also sound in the hallways to alert staff to a resident's call for assistance. Staff is expected to respond to

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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 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) any form of call bell within 15 minutes. All staff employed by the facility is expected to respond to a call bell if they are walking past a room and notice the light is on outside the resident's room. If it is within the job description of the person answering the call bell, the staff person is expected to meet the resident's need and turn off the call bell. If the staff person responding to the call bell is unable to assist the resident, then they should leave the call bell on and go find someone who is able to assist the resident. A review of the facility's grievance decisions for the months of September 2019 through February 2020 revealed the following: September 10, 2019, Resident 99 reported that staff repeatedly turned her call bell light off without providing her requested care. September 17, 2019, Resident 199's spouse reported staff turned the call bell light off without providing the requested care. September 22, 2019, Resident 195's daughter reported staff turned the call bell light off without providing care resulting in incontinence. November 11, 2019, Resident 124's family reported staff turned the call bell light off without providing requested care. December 9, 2019, Resident 203 reported he rang the call bell for his roommate, staff turned off the call light without providing care. December 16, 2019, Resident 312 stated that the nurse aides will turn his call bell light off and leave without providing care. January 16, 2020, Resident 190's family reported that on three occasions over an hour time period three staff entered the room, was told Resident 190 needed care, and they left without providing the care. February 3, 2020, Resident 313's family reported staff turned the call bell light off without providing care. During a group interview with nine residents on March 8, 2020, at 10:00 AM Residents 195 and 165 voiced concerns that staff will respond to the call light, turn it off, but not provide the care that was requested. Resident 195 stated that staff took two hours one evening to answer her call bell. Resident 195 stated that the wait resulted in her having urinary incontinence; following which the licensed nurse yelled at her for making a mess. Resident 195 did not remember the exact day or date but indicated that it occurred within the last two weeks. Observation of the Keystone Nursing Unit on March 7, 2020, at 1:24 PM revealed Resident 138 sitting in his wheelchair outside his room. The call bell light for his room was lit a white color. Continued observation of Resident 138 on March 7, 2020, at 1:28 PM revealed activity staff stopped to ask him if he was coming down to the activity room for a scheduled music activity. Resident 138 stated that he would, but he was waiting for someone to take him to the bathroom for a bowel movement. The activity staff stated that they would try to find somebody. Continued observation of Resident 138 on March 7, 2020, at 1:31 PM, revealed Employee 5, licensed practical nurse, passed Resident 138. Resident 138 stated that he was waiting to have a bowel movement. Employee 5 stated that she would see if she could find somebody and turned the call bell light off. Employee 5 did not provide care to Resident 138 at the time that she turned the call bell light off. Observation of Resident 116 (in the room next to Resident 138) on March 7, 2020, at 1:31 PM, noted the call light outside his room lit white. Employee 4, nurse aide, entered Resident 116's room, Resident 116 stated that he needed to use the bathroom, Employee 4 asked if he needed one or more staff assistance, turned off his call light, and exited the room to take Resident 138 to the bathroom. Resident 116 did not have his needs met; however, his call bell light did not remain activated. Continued observation of Resident 138 on March 7, 2020, at 1:33 PM, revealed Employee 4, nurse aide, approached him and Resident 138 stated to Employee 4, .please get me on the toilet. Employee 4, then, took Resident 138 to the bathroom. Employee 4 left Resident 116 on March 7, 2020, at 1:35 PM, and went down the hall; Resident 116's call bell light remained off. Interview with Resident 116 on March 7, 2020, at 1:44 PM, revealed that he was still waiting to use the bathroom. Observation of Resident 116 on March 7, 2020, at 1:48 PM (approximately 15 minutes after staff turned his call bell light off), revealed staff transferred him to the bathroom. The surveyor reviewed the above findings during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 1 (registered nurse assessment coordinator) on March 9, 2020, at 2:00 PM. Interview with the Nursing Home Administrator on March 10, 2020, at 11:50 AM, confirmed that the facility's call bell log system reports did not reflect the surveyor's observations for Residents 116 and 138 on March 7, 2020, as noted above. The call bell log system reports did not include bathroom call bell activations. The Nursing Home Administrator indicated that he contacted the information technology consultant for the call bell system; however, has not received any response as of that time. Interview with Resident 53 on March 8, 2020, at 9:30 AM revealed that every morning, around 4:30 AM, an oriental woman comes in to get his roommate ready for the day. Resident 53 stated that this staff has the biggest (profanity) mouth I ever heard; and, it's not fair to me because I'm trying to sleep. Resident Grievance Forms completed by Resident 138, who resides on the same hall as Resident 53, dated January 21, 2020, and February 17, 2020, reported a concern that third shift staff are very loud when providing care to his roommate. The facility's corrective action in response to the January 21, 2020, grievance was to educate staff to be quiet during the 11:00 PM through 7:00 AM shift. The facility repeated this intervention following the February 17, 2020, grievance. The facility also suggested to Resident 138 that he change his room. The facility failed to attempt another intervention to correct the third shift staff's behavior of disturbing residents during hours of sleep; but, suggested that the resident move from his roommate who required care during the night. This intervention failed to address how the third shift staff's behavior had the potential to affect other residents on that nursing unit. During a group interview with nine residents on March 8, 2020, at 10:00 AM, Residents 53 and 138 voiced concerns regarding third shift staff continuing to talk loudly when entering their rooms and providing care to their roommates while they are trying to sleep. 483.10(j) Grievances Previously cited deficiency 5/3/19 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(j) Resident rights 28 Pa. Code 211.12(a)(c)(d)(5) Nursing services
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 observation, clinical record review, and resident and staff interview, it was determined that the facility failed to provide personal hygiene assistance and feeding assistance for three of five residents reviewed for activities of daily living (Residents 16, 141, and 142). Findings include: Clinical record review of Resident 16's most recent Minimum Data Set (MDS, an assessment tool completed at specific intervals to determine care needs) dated December 10, 2019, revealed facility staff assessed the resident as being totally dependent on two plus staff for personal hygiene. An observation of Resident 16 on March 7, 2020, at 2:15 PM revealed the resident sitting in a common area watching television, he had a small mustache, and the rest of his face was all whiskers. Upon interview, the resident stated he likes the mustache but prefers to be clean shaven. Clinical record review for Resident 142 revealed a significant change MDS dated [DATE], in which facility staff assessed the resident as requiring extensive assistance of one person for personal hygiene. An observation of Resident 142 on March 8, 2020, at 11:01 AM revealed the resident was in his room, sitting in his wheelchair, and visiting with a family member. The resident's face was covered in whiskers. The resident stated he didn't have a chance to shave himself. The family member present indicated the resident has not been able to shave himself, and that the resident was always a clean-shaven man and would have never let his facial hair get to this point. The above findings were reviewed during an interview with the Nursing Home Administrator and Employee 7, Interim Director of Nursing, on March 9, 2020, at 2:00 PM regarding Resident 16 and 142. Review of Resident 141's clinical record revealed an MDS dated [DATE], indicating that the facility assessed him as needing the total dependence of one staff member to eat. Dietary assessment documentation dated February 7, 2020, at 1:14 PM revealed that Resident 141 has been identified as having lost a significant amount of weight in the past six months, which has now stabilized. The documentation continued to indicate that although Resident 141 will feed himself a few bites, he loses interest and requires feeding to complete the meal. Observation of Resident 141 on March 7, 2020, at 11:41 AM revealed he was sitting in the dining room in front of his lunch meal. Resident 141 was constantly fidgeting with his utensils and napkin, placing mugs of liquid on top of his bowls of food, attempting to cut his lift pad straps with a spoon, and placing a spoon full of pureed food on the table. Resident 141 had no interest in eating. Resident 141 continued with this behavior until 12:03, 22 minutes after receiving his meal, before nursing staff attempted to prompt him or assist him to eat. The above findings were reviewed during an interview with the Administrator and Employee 7 on March 9, 2020, at 2:30 PM, regarding Resident 141. 483.24(a)(2) ADL Care Provided for Dependent Residents Previously cited 5/3/19 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) Based on observation, review of clinical records, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding the assessment of a positioning device, restorative nursing, and physician orders [REDACTED]. Findings include: Interview with the Administrator on March 10, 2020, at 12:59 PM confirmed that the facility does not have a policy or procedure for the use and assessment of positioning devices. Observation of Resident 141 on March 7, 2020, at 10:30 AM revealed he was sitting in a wheelchair with a C shaped pillow around his neck, commonly known as a travel pillow. The open part of the pillow was under Resident 141's chin. Observation of Resident 141 on March 8, 2020, at 10:11 AM revealed he was in bed with the travel pillow around his neck. The open part of the pillow was under Resident 141's chin. Interview with the Administrator on March 9, 2020, at 11:00 AM confirmed that the facility did not have any documented evidence for the use and assessment of Resident 141's travel pillow. The facility policy entitled, physician's orders [REDACTED]. Clinical record review for Resident 3 revealed a current physician's orders [REDACTED]. Observation of Resident 3 on March 7, 2020, at 10:23 AM revealed that she was sitting in her recliner without her tubi-grips on her bilateral lower extremities. On March 8, 2020, at 11:03 AM Resident 3 was dressed and sitting in her wheelchair in her room. She did not have her tubi-grips on her lower extremities. When asked if staff apply them, Resident 3 indicated they do, but haven't got here yet. Further review of Resident 3's clinical record revealed physician orders [REDACTED]. Review of Resident 3's weights revealed that staff failed to complete a weight on the following dates: December 21, 29 and 30, 2019 January 2, 15, and 18, 2020 February 9 and 15, 2020 March 1, 2020 Clinical record review for Resident 4 revealed a care plan intervention dated January 2, 2020, indicating the nursing staff would perform restorative nursing in the form of active (staff encourage resident to perform as much as possible) range of motion (ROM, exercises to preserve flexibility and mobility of joints) to his lower extremities with care as tolerated. Interview with Resident 4 on March 7, 2020, at 10:23 AM revealed that he goes to therapy either in his room or there (in the therapy room) but could not provide any further details as to dates, times, and/or frequency of therapy visits. Review of Resident 4's tasks (documentation to indicate that staff completed a resident need/obligation) revealed that there was no documentation that staff performed active ROM to his lower extremities until after identified by the surveyor. There was no documentation that Resident 4 refused to complete his active ROM exercises. Clinical record review for Resident 104 revealed a care plan intervention for nursing staff to perform restorative nursing in the form of passive (staff performs) ROM to her bilateral (b/l, both) lower extremities during care as tolerated. Resident 104 was also care planned to receive restorative nursing in the form of active ROM to her b/l upper extremities during care as tolerated. Review of Resident 104's tasks for passive ROM to her b/l lower extremities revealed that there was no documentation that staff completed her restorative nursing program on the following dates and times: January 2, 10, 16, 17, and 18, 2020, day shift January 16, 17, and 18, 2020, evening shift February 3, 8, 9, 13, 17, 20, 22, and 23, 2020, day shift February 1, 7, 15, 16, 20, and 21, 2020, evening shift March 5, 2020, evening shift Further review of Resident 104's tasks for active ROM to her b/l upper extremities revealed that there was no documentation that staff completed her restorative nursing program on the following dates and times: February 17, 20, 22, and 23, 2020, day shift February 15, 16, 20, and 21, 2020, evening shift March 5, 2020, evening shift Clinical record review of Resident 158 revealed current physician orders [REDACTED]. Observation on the following dates and times revealed that Resident 158 did not have either her Isotoner glove or her geri-sleeves on: March 8, 2020, at 9:32 AM and 11:15 AM March 9, 2020, at 9:21 AM Concurrent interview and observation on March 9, 2020, at 9:21 AM with Employee 1, registered nurse assessment coordinator, confirmed that Resident 104 did not have her geri-sleeves on. When asked where the sleeves were, Employee 1 found them along with her Isotoner glove in a cupboard drawer behind Resident 104's bedroom door. The surveyor reviewed the above information for Residents 3, 4, 104, and 158 during an interview with the Nursing Home Administrator on March 9, 2020, at 2:00 PM. 483.25 Quality of Care Previously cited 6/12/19 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of select facility policies, and staff interview, it was determined that the facility failed to implement interventions to prevent pressure ulcers for two of 14 residents reviewed (Residents 142 and 158). Findings include: The facility policy entitled, Pressure Ulcer - Risk Assessment, Prevention of Skin Breakdown and Skin Care Management, last reviewed without changes on January 23, 2020, revealed that the facility is committed to providing a comprehensive pressure ulcer prevention and management program to ensure that residents admitted to the facility without pressure ulcers do not develop them unless the individual's clinical condition demonstrates they are unavoidable. Any resident with a pressure ulcer will receive treatment and services consistent with the resident's goals of treatment, with one being to promote healing and preventing infection. Clinical record review for Resident 158 revealed current physician orders [REDACTED]. Every shift staff was to ensure that the air mattress cycle (how fast the air pressure location cycles/changes in the mattress) was set at five minutes. Staff was to off-load pressure (remove the pressure) from Resident 158's heels. Review of Resident 158's pressure ulcer documentation revealed that she currently has an unstageable (depth unable to be determined) pressure ulcer measuring 1.6 centimeters (cm) by 1.2 cm by 0.2 cm located on her right heel and a stage IV (a pressure ulcer involving the muscle/tissues) on her left ischium (lower left butt cheek area) measuring 2.7 cm by 2.2 cm by 1.7 cm with undermining (outer skin is hanging over the wound) at 11:00 AM and 2:00 PM if visualized utilizing a clock face placed on the wound with 12 o'clock being at the resident's head. Observation on March 7, 2020, at 10:48 AM and March 8, 2020, at 9:16 AM and 9:32 AM revealed that Resident 158's APM cycle was set on 20 minutes per cycle not 5 minutes as ordered. Resident 158 was in her bed during the March 8, 2020, observations. Observation of Resident 158 on March 8, 2020, at 9:16 AM and 9:32 AM, and March 9, 2020, at 9:21 AM revealed that her heels were not off-loaded as ordered while she was in bed. On March 8, 2020, at 11:15 AM and March 9, 2020, at 12:22 PM Resident 158 was in her wheelchair with her legs elevated and heels sitting on calf pads. Her heels where not off-loaded as ordered while she was in her chair. This surveyor reviewed the above information with the Nursing Home Administrator on March 9, 2020, at 2:00 PM. Clinical record review for Resident 142 revealed the resident was admitted to the facility in November 2019, with a wound to his right knee. Further review revealed the resident was seen by the wound clinic on December 2, 2019, for the right knee. The report indicated the resident's heels were evaluated and no open ulcerations or alterations were present. The report indicated physical and occupational therapy and a pressure reducing mattress as interventions. The knee wound was noted as resolved on December 9, 2019. A wound clinic report dated February 3, 2020, revealed the resident was now being seen due to a left hip surgical site from recent surgery, and a full thickness ulceration of the left heel measured 3.8 cm, by 4.1 cm with no depth. The area was noted as deep red tissue with purplish discoloration and identified as an unstageable pressure ulcer/injury of the left heel secondary to a deep tissue injury. The interventions listed included a pressure reducing mattress, physical and occupational therapy, and the use of a heels up device. A late entry nurse's note dated February 12, 2020, for February 10, 2020, noted the left heel deep tissue injury as resolved and preventative measures were in place. A nurse's note dated February 16, 2020, noted the resident's heels up device does not stay in place causing more pressure on his heels, and that a referral was placed for therapy to assess and possibly place the resident in Posey boots (special padded foot coverings to aid in the prevention of skin breakdown) while in bed. On February 17, 2020, the wound clinic report noted the resident as having a Stage II pressure injury of the left heel measuring 5.1 cm x 6.7 cm. There was no evidence of an order or that communication took place with therapy after the February 16, 2020, nursing note, regarding the assessment of Posey boots for Resident 142. an order for [REDACTED]. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.12 (d)(1)(2)(5) Nursing services
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of select policies and procedures, and resident and staff interview, it was determined that the facility failed to initiate a restorative range of motion program, and assess and implement interventions for a decline in range of motion for four of nine residents reviewed (Residents 68, 82, and 203). Findings include: The policy entitled Restorative Nursing, last reviewed without changes on January 23, 2020, indicates that all residents who are admitted to the facility are evaluated by the therapy department to determine their basic needs. The therapy department will determine if they will initiate therapy or refer the resident to the restorative nursing coordinator for placement in the restorative program. Restorative programs are to be completed daily as the resident

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) tolerates and will be charted in the kiosk daily. The restorative nursing coordinator will supervise the caregiver and monitor progress of all residents on the individual programs. The designated member of Nursing Administration will oversee the restorative program and meet with the restorative nursing coordinator and aides on a regular basis. Review of Resident 203's clinical record revealed a Minimum Data Set Assessment (MDS, an assessment tool completed at specific intervals to determine care needs) dated August 11, 2019, which indicated the facility assessed him as now having a new onset of limited range of motion on one side of his upper extremities. The facility's MDS assessments for September 2, 2019, December 2, 2019, and February 26, 2020, all continued to reflect the facility's assessment indicating Resident 203 had limited range of motion on one side of his upper extremities. Review of Resident 203's clinical record revealed no documented evidence that the facility responded to his change in range in motion with a therapy evaluation or implemented a restorative program for his upper extremities. Interview with Employee 1, Registered Nurse Assessment Coordinator, on March 10, 2020, at 1:11 PM confirmed the above findings for Resident 203. Clinical record review for Resident 82 revealed Plan of Care documentation dated October 26, 2018, at 7:36 AM, indicating that she received restorative nursing programs for active range of motion exercises to her bilateral upper and bilateral lower extremities. Quarterly MDS assessments dated April 24, 2019, and July 17, 2019, assessed Resident 82 as having no range of motion impairments to either her bilateral upper or bilateral lower extremities. A quarterly MDS assessment dated [DATE], assessed a decline in Resident 82 to now having range of motion impairment in her bilateral upper extremities. An annual MDS assessment dated [DATE], continued to assess Resident 82 has having range of motion impairment of her bilateral upper extremities. Resident 82's clinical record contained no evidence that the facility identified this decline in Resident 82's range of motion, that skilled therapy evaluated her for appropriate treatment, or that her restorative nursing care was revised to meet her change in condition. Restorative nursing task documentation dated January and February 2020 revealed that nursing staff were to assist Resident 82 with active range of motion exercises twice daily to both her bilateral upper and bilateral lower extremities. Staff failed to document completion of the programs as designed on 14 of the 31 days in January 2020 and 13 of the 29 days in February 2020. Plan of Care documentation dated January 20, 2020, at 9:51 AM stipulated that Resident 82 was to receive restorative nursing rehabilitation for passive range of motion to her bilateral lower extremities as tolerated with care; and that the writer would continue to monitor that Resident 82 would maintain her level of functioning since her last MDS review. The Plan of Care documentation failed to identify that staff were to assist Resident 82 with active (not passive) range of motion exercises, that she was to receive treatment to both her upper and lower extremities (not just her lower), or that staff failed to implement the program as evidenced by the task documentation. The surveyor reviewed the above findings for Resident 82 during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 1, on March 9, 2020, at 2:50 PM. Interview with Resident 68 on March 7, 2020, at 10:35 AM revealed that she was discharged from all her therapies in February 2020. She indicated that since that time she is not getting any exercise and she still has a hope of going home. Clinical Record review of Resident 68's nursing documentation survey report (daily documentation of the resident's care) for the month of February 2020, revealed that Resident 68's range of motion program to her bilateral lower extremities was initiated on February 10, 2020. Review of the documentation revealed that the program was not completed 12 times. Review of the documentation for Resident 68's range of motion to her bilateral upper extremities for the month of February 2020, revealed that the program was not completed 11 times. Interview with Employee 1, Registered Nurse Assessment Coordinator, at 12:10 PM on March 10, 2020, confirmed that the range of motion program for Resident 68 should have been completed. 28 Pa. Code 211.12(d)(1)(5) Nursing services
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to thoroughly investigate accidents and injuries of unknown origin to prevent further incidents for two of 13 residents reviewed (Residents 56 and 179), and implement interventions to prevent falls for four of 13 residents reviewed (Residents 3, 56, 142, and 82). Findings include: Review of Resident 56's MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) with an ARD (Assessment Reference Date, the last day in an MDS Assessment observation period) date of December 9, 2019, revealed the resident had a BIMS of four (BIMS, Brief Interview for Mental Status, assessment that scores a resident's response to memory questions; a score of zero to seven indicates severe impairment). The resident required limited assistance of one staff member for transfers, walking, and toileting. The resident's balance was not steady and only able to stabilize herself with human assistance when moving from a seated to a standing position. Review of Resident 56's plan of care for falls dated December 3, 2019, revealed that the resident is a moderate risk for falls related to confusion and deconditioning (a deficit in physical functioning). Review of Resident 56's behavioral monthly flow sheets for December 2019 through February 2020, revealed the resident exhibited the behaviors of wandering and restlessness daily. Review of Resident 56's MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) with an ARD (Assessment Reference Date, the last day in an MDS Assessment observation period) date of December 9, 2019, revealed the resident had a BIMS of four (BIMS, Brief Interview for Mental Status, assessment that scores a resident's response to memory questions; a score of zero to seven indicates severe impairment). The resident required limited assistance of one staff member for transfers, walking, and toileting. The resident's balance was not steady and only able to stabilize herself with human assistance when moving from a seated to a standing position. Review of Resident 56's plan of care for falls dated December 3, 2019, revealed that the resident is a moderate risk for falls related to confusion and deconditioning (a deficit in physical functioning). Review of Resident 56's behavioral monthly flow sheets for December 2019 through February 2020, revealed the resident exhibited the behaviors of wandering and restlessness daily. Review of facility documentation for Resident 56 dated December 15, 2019, revealed the resident was found on the floor near the nurse's station and living room door entrance at 11:35 AM. Her wheelchair was behind and to the side of her. The resident sustained [REDACTED]. There were no witness statements associated with this fall investigation. Review of IDT (Interdisciplinary Team, members from various departments reviewing and planning care) notes dated December 17, 2019, revealed the root cause of the incident was that the resident was not being occupied appropriately. The resident was to be re-evaluated on activities. There was no documented evidence that the resident was re-evaluated for activities or a change in the resident's plan of care after this fall until January 3, 2020. The facility failed to thoroughly investigate this incident or implement activities to keep her occupied. Review of facility documentation for Resident 56 dated December 19, 2020, revealed the resident was found lying on the floor near the nursing station with two linen carts near her at 9:00 PM. One linen cart had a bag that was pushed all the way down to the bottom of the cart. The nurse indicated that the resident frequently ambulates in the hallway pushing a linen cart or a wheelchair. The resident's non-skin socks were noted to have poor tread and were replaced. Review of facility documentation for Resident 56 dated December 20, 2019, revealed that another resident told the staff that Resident 56 fell at 9:45 AM. Witness statements revealed that she was seen five minutes earlier grabbing at the LPN's (licensed practical nurse) uniform and minutes before by a nurse aide. It was documented on the witness statement that the resident tends to lean forward in her wheelchair and tends to lean forward to grab anyone near her, which could have caused the fall. The resident's wheelchair was behind her. The abrasion to the bridge of the resident's nose opened more and became a laceration. A skin tear was noted to the resident's right hand with a moderate amount of bleeding. The resident was noted to be stuporous (a level of alertness in which the person is almost unresponsive and only responds to intense stimuli such as pain or vigorous stimulation). The resident was sent to the emergency room by ambulance. Review of a nursing progress note dated December 21, 2019, at 10:25 AM revealed Resident 56 was admitted to the hospital with [REDACTED]. Prior to the fall, the resident was last seen propelling herself in the wheelchair down the hall. The surveyor reviewed the above findings for Resident 56 during an interview with the Nursing Home Administrator and Employee 17, Director of Therapeutic Recreation on March 10, 2020, at 10:30 AM. Clinical record review for Resident 82 revealed a plan of care initiated August 24, 2018, to address her high risk for falls related to her unsteady gait and history of multiple falls. Nursing documentation dated January 4, 2020, at 2:45 AM revealed that staff found Resident 82 lying on the floor on the left side of her bed. Staff assessed Resident 82 to have a bruise above her right eye measuring 3 cm by 3 cm. Resident 82 complained of a headache and staff administered Tylenol (over-the-counter mild [MEDICATION NAME]). Review of the facility's investigation dated January 4, 2020, at 2:45 AM revealed that the facility stipulated the new intervention to prevent further injury would be a fall mat

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) to the left side of Resident 82's bed. Review of Resident 82's plan of care for her fall risk included a fall mat to the left side of her bed as of January 4, 2020. Review of an Incident Audit Report documentation dated January 9, 2020, at 2:01 PM, revealed that the interdisciplinary team agreed that the root cause of the January 4, 2020, incident was that Resident 82 rolled out of bed, was utilizing a regular mattress, and that the facility would revise her plan of care to include a perimeter defining mattress (mattress with raised edges to deter rolling out of bed) and a fall mat. Nursing documentation dated January 17, 2020, at 6:54 PM revealed Resident 82 was laying on her back on the left side of her bed (between the beds). The documentation stipulated that Resident 82's fall mat was on the right side of her bed (the wrong side). The documentation indicated that the new intervention to prevent injuries from falls would be a fall mat to the left side of Resident 82's bed. Review of the facility's investigation of Resident 82's fall on January 17, 2020, failed to identify the failure of staff to place the fall mat on the left side of Resident 82's bed before her fall. The investigation failed to identify that the planned intervention of a perimeter defining mattress remained omitted from Resident 82's environment and plan of care. Nursing documentation dated January 21, 2020, at 6:15 AM revealed that staff found Resident 82 lying on the fall mat on the left side of her bed. Resident 82 stated that she tried to roll out of bed. Review of the facility's investigation of Resident 82's fall on January 21, 2020, at 6:15 AM revealed that the facility identified Resident 82 remained on a regular mattress and again noted the new intervention to prevent future falls would be a perimeter defining mattress. The facility added the perimeter defining mattress to Resident 82's fall risk plan of care on January 21, 2020. Other interventions to prevent future falls indicated that the facility initiated positioning of the right side of Resident 82's bed against the wall (although Resident 82's repeated falls were from the left side of her bed) on January 23, 2020. Nursing documentation dated January 30, 2020, at 7:05 AM revealed that staff again found Resident 82 next to her bed, on her fall mat. Review of the facility's investigation dated January 30, 2020, at 7:05 AM failed to identify that Resident 82 again fell from the left side of her bed (determined by the surveyor because the right side of her bed was against the wall per her plan of care). Observation of Resident 82 on March 7, 2020, at 11:19 AM revealed she was in bed with the right side of her bed against the wall. The surveyor confirmed the above findings regarding Resident 82's repeated falls during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 1, Registered Nurse Assessment Coordinator (RNAC) on March 9, 2020, at 2:50 PM. Clinical record review for Resident 179 revealed nursing documentation dated November 3, 2019, at 12:09 PM that nurse aide staff notified the licensed nurse that Resident 179 had a bruise on her right hip. Nursing documentation dated November 3, 2019, at 12:42 PM revealed that staff discovered a light purple/bluish bruise measuring 7.4 cm by 4.5 cm to Resident 179's right upper hip/waist area. The documentation stipulated that Resident 179 received [MEDICATION NAME] (an anticoagulant meant to prevent the blood from clotting) injections daily. Nursing documentation dated November 4, 2019, at 12:15 AM revealed that staff noticed a large, raised, lump, on Resident 179's right abdomen, under the bruised area. The raised area was firm, not hard, moved slightly when Resident 179 moved, and was not discolored. Nursing documentation dated November 4, 2019, at 6:56 AM revealed that the facility sent Resident 179 to the emergency room for evaluation of her worsening right lower quadrant abdominal distention. History and Physical documentation by the hospital dated November 4, 2019, revealed that Resident 179 presented with a 14 cm by 10 cm superficial abdominal wall hematoma outside the musculature that was seen on CT scan and on physical exam. Resident 179's hemoglobin was dropping; and her [DIAGNOSES REDACTED]. The documentation stipulated that Resident 179 had a, large abdominal wall hematoma secondary to trauma from [MEDICATION NAME] needle injection. Nursing documentation dated November 9, 2019, at 6:44 PM revealed that the facility readmitted Resident 179. Nursing documentation dated November 20, 2019, at 12:03 PM revealed that Resident 179 returned from a consult appointment for follow up after surgery, status [REDACTED]. Review of the facility's investigation of Resident 179's bruise discovered on November 3, 2019, at 12:06 PM revealed that the IDT reviewed the incident and agreed that the root cause of the incident was that Resident 179 received [MEDICATION NAME] injections and that bruising does occur. The investigation failed to obtain statements from the licensed staff who administered the [MEDICATION NAME] injections most recently before the identification of the bruise to determine if anything untoward occurred during the administrations; or if there was any reason for concern regarding the quality and function of the prefilled [MEDICATION NAME] injectable equipment. The facility's investigation failed to thoroughly investigate if the licensed nurse who administered the [MEDICATION NAME] injection to Resident 179's left lower abdominal quadrant on November 3, 2019, at 8:00 AM, assessed anything abnormal from the November 2, 2019, [MEDICATION NAME] injection to Resident 179's right upper abdominal quadrant (since the bruise was identified on the right). The surveyor reviewed the findings regarding Resident 179's bruise during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 1, on March 9, 2020, at 2:00 PM. Interview with Employee 1 on March 10, 2020, at 12:05 PM confirmed that the facility was unable to provide any evidence of competency evaluations for the two licensed practical nurses who administered Resident 179's [MEDICATION NAME] injections for the dates of November 1 through 3, 2020. Clinical record review for Resident 3 revealed current physician's orders [REDACTED]. Nursing documentation on January 11, 2020 at 6:10 PM revealed that Resident 3 was lying on the floor. Staff noted that Resident 3 forgot to lock her wheels on her wheelchair before she stood up to use the restroom and fell on her bottom. Resident 3 did not sustain injuries from the fall. Observation of Resident 3 on March 8, 2020, at 11:05 AM revealed that she did not have an anti-roll back device on her wheelchair. A purchase order provided to the surveyor on March 10, 2020, after questioning, revealed that the facility sent a request to the Nursing Home Administrator to purchase an anti-roll back device for Resident 3's wide wheelchair. The facility failed to implement Resident 3's physician's orders [REDACTED]. The surveyor reviewed the above information regarding Resident 3 during an interview with the Nursing Home Administrator on March 9, 2020, at 2:00 PM. In an observation and interview with Resident 142 and a family member on March 8, 2020, at 11:02 AM the family member stated the resident has an ankle brace for his left foot/ankle for stability, that the resident had prior to admission. The family member stated he was wearing it at the facility. The resident was sitting in his wheelchair beside his bed and he was not wearing an ankle brace. In the same interview, Resident 142 stated he has rolled out of bed a couple times and fell on ce in therapy. He stated he had just rolled out of bed the night before. A mattress with defined edges was observed on the resident's bed as well as a fall mat on the floor. The resident stated he rolled over and went right out the side of the bed. Clinical record review for Resident 142 revealed a physician's orders [REDACTED]. The resident's plan of care for fall prevention also indicated a left ankle brace to be worn when out of bed dated December 2, 2019. Upon interview with Employee 1 on March 9, 2020, at 2:50 PM she indicated the resident is only to wear the brace for transfers due to a pressure area on his left heel. A physician's orders [REDACTED]. as noted above. Further clinical record review for Resident 142 revealed the resident had a fall from bed on December 10, 2019. Review of facility documentation of the fall indicated a maintenance request was sent to change the resident's mattress to a perimeter defined mattress (a mattress with raised sides to aid in the prevention of rolling out of bed). Resident 142 was then noted on December 12, 2019, at 6:00 AM to be found on the floor by his bed, at which time the resident indicated he rolled over and ended up on the floor. A fall mat was noted to be added to the to the side of his bed. Resident 142 was again found at the side of his bed on December 20, 2019. Review of Resident 142's plan of care revealed a perimeter defined mattress was not added to the resident's plan of care until December 24, 2019. Review of facility documentation did reveal the resident had a fall on March 8, 2020 during the night as the resident had indicated in the resident interview noted above. The documentation revealed the resident was again found on the fall mat beside his bed. An intervention on the facility documentation completed by a registered nurse indicated a new order for a perimeter defined mattress was placed and that the mattress was obtained and put in place; an intervention that was already noted as requested on December 10, 2019, and added to the resident's plan of care on December 24, 2019. The above findings were reviewed with the Nursing Home Administrator and Employee 7, Interim Director of Nursing on March 9, 2020, at 2:30 PM. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.11(d) Resident care plan 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to provide respiratory therapy care consistent with professional standards for two of three residents reviewed for oxygen/[MEDICAL CONDITION] use (Residents 35 and 114). Findings include: Clinical record review for Resident 35 revealed the resident has a [DIAGNOSES REDACTED]. An observation of Resident 35 on March 7, 2020, at 1:31 PM revealed the resident was in bed with the nasal cannula in place, with oxygen being administered at three and a half liters per minute. The resident stated, I think it is supposed to be set to two or two and a half. A concurrent observation of Resident 35's supplemental oxygen level with Employee 11, licensed practical nurse, confirmed the oxygen level was incorrectly set to

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) three and a half liters per minute and should be at two liters per minute and adjusted the setting. In an interview with the Nursing Home Administrator and Employee 7, Interim Director of Nursing, on March 8, 2020, at 2:00 PM the above findings regarding Resident 35's oxygen settings were reviewed. The facility policy entitled, [MEDICAL CONDITION]/[MEDICAL CONDITION] (non-invasive machines to administer air into the lungs, to treat a diagnosed airway obstruction) last reviewed on January 23, 2020, revealed that after removing the unit from the resident, staff should wipe the face mask off with a moist towel or alcohol pad and place it in a setup bag for storage and infection control purposes. The machine, mask, tubing, and humidifier chamber will be cleaned monthly and as needed by the contracted respiratory provider. Observations on March 8, 2020, at 10:03 AM, and March 9, 2020, at 9:48 AM revealed Resident 114 had a [MEDICAL CONDITION] machine on her bedside stand. The mask to the [MEDICAL CONDITION] on the bedside stand was uncovered. There was an opened gallon of distilled water on the floor of the resident's room and it was not labeled with a date when open. Concurrent interview with Resident 114, revealed she pointed to the [MEDICAL CONDITION] when asked her what the water was for. Observations on March 9, 2020, at 11:56 AM revealed the distilled water on the floor of Resident 116's room and the [MEDICAL CONDITION] mask was contained in a plastic bag. Concurrent interview with Employee 24, licensed practical nurse, revealed that the distilled water was for the [MEDICAL CONDITION] machine and she discarded it. The surveyor reviewed the above findings for Resident 114 during an interview with the Nursing Home Administrator on March 10, 2020, at 12:17 PM. 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on observations, resident and staff interviews, group interview, and review of facility documents, it was determined that the facility failed to ensure sufficient nursing staff for one of five nursing units (Keystone Unit and Residents 26, 53, 58, 60, 64, 98, 118, 137, 138, 169, and 187). Findings include: Observation on the Keystone Unit on March 7, 2020, at 9:30 AM revealed Residents 98 and 58 in bed. Concurrent interview with Resident 98 revealed that they (her and her roommate) did not get their breakfast tray yet. She stated she is usually in the dining room to eat breakfast. Residents 187 and 64 were still in bed at 9:36 AM and stated they did not eat breakfast yet. Concurrent interview with Resident 187 revealed that she is to be out of bed for meals and someone must watch her because she choked once. Resident 64 revealed that she normally is out of bed and in the dining room to eat. Continued observation revealed breakfast trays being delivered to Residents 58 and 98 at 10:00 AM, and to Residents 187 and 64 at 10:02 AM. Staff served their breakfast trays in bed. Interview with Employee 4, nurse aide, at 10:30 AM revealed that they only had two nurse aides on the floor from start of the shift, 6:45 AM until about 7:45 AM. She stated that they did not realize that one nurse aide called off and another nurse aide, Employee 8, was pulled to a different unit. Once they realized it, Employee 8 was brought back to the Keystone Unit at 7:45 AM, so they had 3 nurse aides for 58 Residents, but they were already behind. Observation on the Keystone Unit on March 7, 2020, revealed that the lunch trays arrived at 11:38 AM. Employee 9 (Maintenance Director) and Employee 10 (Housekeeper) started passing the trays at 11:41 AM. There were no direct care staff assisting with delivering trays until 11:51 AM. Interview with Employee 12, Registered Nurse, at 12:05 PM on March 7, 2020, revealed that trays were delivered late and residents were still in bed because of a staffing issue, as it always is. She also stated that Resident's that are in their rooms who usually eat in the dining room will have their trays brought up to the unit later. She was unsure of a time. Observation of Resident 58 and 98 at 12:50 PM revealed they were still in bed. Resident 98 stated that no one got her up to go to the dining room, so she is eating in bed. Trays were delivered to Residents 58 and 98 at 1:00 PM. Observation of Resident 169 revealed her receiving a tray in her room at 1:00 PM. She stated that she usually eats in the dining room. Observation of Residents 64 and 187 revealed them both still in bed at 12:30 PM. Concurrent interview with Resident 187 revealed that she usually eats in the dining room known as the tv room. She stated that the staff told her she would be eating in her room today because there was no time to get her up. Concurrent interview with Resident 64 revealed that she usually eats in the dining room on the unit, but staff told her she would be eating in her room today. Lunch trays were delivered to Residents 64 and 187 at 1:05 PM in their room. A group interview on March 8 at 10:00 AM revealed Residents 26, 53, 60, 118, 137, and 138 all reside on Keystone Hall. They voiced concerns about the staffing problems. They stated that on March 7, 2020, they never received their breakfast trays until 10:00 AM-10:30 AM. They stated that the normal time is to be around 8:30 but usually they don't get them until around 9:00. They stated that there are usually only 2-3 nurse aides to pass trays and feed 58-60 residents. Resident 26 revealed that the staff will not take him to the bathroom after meals until all residents are fed and trays are picked up. He stated that it is hard for him to hold it. They tell him there is not enough staff to take residents to the bathroom while they are serving or feeding other residents. Review of the facility staffing deployment for March 7, 2020, for the Keystone Hall revealed there were four nurse aides scheduled. One nurse aide called off and one was pulled from 6:45AM to 7:45 AM to another unit. There was one licensed practical nurse assigned to administer medications and one registered nurse administering medications. During observation on the nursing unit on March 7, 2020 from 9:30 to 10:30 AM the Registered nurse did not assist with delivery of meal trays or feeding residents. The facility failed to ensure sufficient staff to meet the needs of the residents on the Keystone Unit on March 7, 2020. The surveyor reviewed the above findings related to sufficient staff on the Keystone Unit during an interview with the Nursing Home Administrator and Employee 7 (interim Director of Nursing) on March 9, 2020 at 2:15 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Post nurse staffing information every day.** Based on observation, documentation review, and staff interview, it was determined that the facility failed post at the beginning of each shift the nurse staffing information in a prominent place readily accessible to residents and visitors. Findings include: Observation on March 7, 2020, at 8:50 AM, at the start of the survey, the nurse staffing sheet posted was dated for March 5, 2020, inclusive of three shifts on that date. The facility failed to post the required staffing information for each shift for two consecutive days. The surveyor reviewed the above findings with the Nursing Home Administrator on March 7, 2020, at 10:50 AM. 28 Pa. Code 211.12(k) Nursing services
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policies and procedures, observation, and staff interview, it was determined that the facility failed to properly store controlled medications in one of five medication storage rooms (Klineway, Residents 45 and 162). Findings include: The facility policy entitled, Medication Ordering and Receiving from Pharmacy, last reviewed without changes on January 23, 2020, revealed that medications listed in Schedules II, III, IV, and V are stored under double lock. The access to controlled substances is not the same key/code that allows access to other medications. The facility may designate a drug, which is not mandated as a controlled substance by state or federal laws and subject to abuse or diversion, to be handled under these procedures for controlled substances. Observation of the Klineway nursing unit medication storage room on March 10, 2020, at 11:13 AM with Employee 2 (licensed practical nurse), revealed a locked refrigerator with a removable shelf that was equipped with an affixed clear plastic box containing [MEDICATION NAME] ([MEDICATION NAME], classified as Schedule IV antianxiety medication) for Residents 45 and 162. The surveyor easily removed the refrigerator shelf from the lockable refrigerator. Employee 2 confirmed that this refrigerator contains non-controlled medications that require refrigeration such as insulins, immunizations, etc.; thus, not providing separately locked, permanently affixed, storage for medications subject to abuse. The surveyor reviewed the above findings during an interview with the Nursing Home Administrator on March 10, 2020, at 11:50 AM. 483.45(g)(h)(1)(2) Label/store Drugs and Biologicals Previously cited deficiency 5/3/19 28 Pa. Code 211.9(k) Pharmacy services 28 Pa. Code 211.12(d)(3) Nursing services
F 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain dental services for each resident.**

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F 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) Based on observation, clinical record review, and staff and resident interview, it was determined that the facility failed to provide dental services for one of three residents reviewed (Resident 197). Findings include: Interview with Resident 197 on March 7, 2020, at 1:31 PM revealed that he has his own teeth. Resident 197 opened his mouth and showed the surveyor that he had broken and decayed teeth. He stated that he is going to have to go to the dentist soon because it has been awhile, and they are starting to bother him. He said he has only seen the dentist once since he has been there. Resident 197 was admitted to the facility June 26, 2016. The Nursing Home Administrator provided evidence that Resident 197 was scheduled to see the dentist on March 25, 2020. He was unable to provide evidence of any past dental services for Resident 197. The surveyor reviewed the above noted findings for Resident 197 during an interview with the Nursing Home Administrator on March 10, 2020, at 9:15 AM. 483.55(b)(1)-(5) Routine/emergency Dental Services In NFs Previously cited deficiency 5/3/19 28 Pa. Code: 211.15 (d) (1) (3) Nursing services 28 Pa. Code: 211.15 (a) Dental services
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on review of select policies and procedures, observation, and resident and staff interview, it was determined that the facility failed to serve food that is attractive and at an appetizing temperature in the facility's main dining room (Rose Caf), and on two of five nursing units (Laurel Circle and Governors, Resident 141). Findings include: Review of a current facility policy entitled, Resident tray Assessment, reveals the facility standard is that foods should be served at the following temperatures: entrees, starches, and vegetables at 135 degrees Fahrenheit, or above, hot beverages 120-160 degrees Fahrenheit, and salads, desserts, fruit, juice, and milk at 41 degrees Fahrenheit or below. An observation in the facility's main dining room Rose Caf on March 9, 2020, at 11:52 AM revealed dietary staff serving resident lunch from a steam table located in the dining room. The last resident was served at 12:05 PM. A mechanical soft meal was requested and served at 12:07 PM. An assessment of the food served with Employee 13, Assistant Director of Nursing, revealed ground meat, identified as ground pork, appeared dry and only warm at 106 degrees Fahrenheit. The above findings regarding the appearance and temperature of food served were reviewed with the Nursing Home Administrator and Employee 7, Interim Director of Nursing, on March 9, 2020, at 2:00 PM. Observation of the Garman caf dining room on March 8, 2020, at 11:10 AM revealed that Resident 141 was not already seated. Resident 141's lunch tray remained on the dietary cart until 11:36 AM, when Employee 15, dietician, loaded his lunch tray on a plastic hand cart and went to the Governors nursing unit. Employee 15 then placed Resident 141's lunch tray at the nurse's station, indicating that Resident 141 was not ready to eat yet. Resident 141's lunch tray remained at the nurse's station until 12:02 PM, when Employee 16, nurse aide, picked up Resident 141's tray and committed to serving him. This surveyor stopped Employee 16 from serving Resident 141 his lunch and assessed the temperatures of his food with the following results: Pureed noodles, 115.9 degrees Fahrenheit Pureed beef, 113.8 degrees Fahrenheit Gravy, 104 degrees Fahrenheit with a congealed top Pureed Broccoli, 118.3 degrees Fahrenheit Pureed Cheesecake, 61 degrees Fahrenheit Orange Juice, 59 degrees Fahrenheit Coffee, 114 degrees Fahrenheit Interview with Employee 16 at this time confirmed all the above food temperatures for Resident 141's lunch tray. Observation of the meal service on the(NAME)Circle Nursing Unit on March 9, 2020, at 11:43 AM revealed that dietary staff overhead paged that the hall cart was on the way to the nursing unit. At 11:46 AM, dietary staff delivered the hall tray cart and staff began immediately serving meals. At 11:52 AM, it was noted that staff left the hall cart door open for approximately one minute while they went to pass a tray. At 12:00 PM, the last tray on the cart was pulled. The surveyor requested a new tray be sent for the resident and immediately began food palatability and tray temperatures with Employee 23, registered nurse, staff development with the following results: The pureed carrots were 104.8 degrees Fahrenheit The pureed pork loin was 103.7 degrees Fahrenheit The gray (moistening agent) was 107.8 degrees Fahrenheit. The surveyor reviewed the above information regarding the(NAME)Circle Nursing Unit's meal tray during an interview with the Nursing Home Administrator on March 9, 2020, at 2:00 PM. 28 Pa. Code 211.6(c) Dietary 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.** 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 five nursing units (Laurel Circle and(NAME)Court). Findings include: Initial tour of the facility's main kitchen on March 7, 2020, at 9:10 AM with Employee 14, dining service supervisor, revealed the following: Debris of dried food and wrappers, some of which appeared to have been wet and dried to the floor were present in the area of the dumpster beside the dish washing area and window area across from the dish washing area. The flooring edges where they meet the wall in the dish washing area around to the food serving area, behind equipment in the food serving area, and the opening between the dish room and food serving area contained black build up on the floor edges. The bumper bases of four glass door coolers in the service area contained dust and debris on the base of each cooler. A two-door cooler in the cold production area contained one bin and one bowl of mandarin oranges in the cooler with no date to indicate when they were placed in the cooler or when the expire. The floor of the cooler had a tray containing packages of V8 and vegetable juice; the tray contained dried purple spills on it. The bottom shelf of the cooler also contained dried purple spills and food debris. A four-tier open metal wire rack with serving equipment and food supplies on it in the cold production area contained dust and debris hanging from the bottom shelf and on the wheelbases. The bottom shelf had no protective barrier to prevent from potential splash of mop water or debris. A plate lowerator that Employee 14 identified as number four, in the serving area was empty. Dark brown buildup was identified throughout the interior of the equipment. A chill blaster (equipment used to cool foods down quickly) in the production area contained dried spills on the interior base, and dried food splatter on the exterior door and sides. The exterior air vent was covered in dust. Employee 14 stated they have not used the chill blaster in long time. A two-door freezer in the cold production area contained seven bags of cauliflower, two strawberry cream pies, one bag of steak fries, and one bag of personal size pizzas, on the shelves. These items did not have any date as to when they were placed in the freezer or when they needed to be used by. A half bag of broccoli, and one bag of sliced carrots were also in the freezer, both of which were frozen in a solid clump, and had no date to indicate when they were placed in the freezer or when they needed to be used by. A walk-in cooler in the food production area contained dried spills and debris on the cooler floor and under shelves. A speed rack holding trays of yogurt and jello, had dried spills and debris on the rack. The dry storage area located beside the production area contained a shelf holding containers of vinegar, oil, mashed potatoes, and stuffing that was covered in dust and food debris. An open box of chocolate chips was observed on a shelf with the interior bag of the chocolate chips wide open and exposed. Two racks of bread products were in the dry storage room. A sign on the bread rack sated, All bread must have a pull date. Employee 14 indicated the bread comes in frozen and staff must remove it from the freezer. Seven loaves of bread, three packs of hamburger buns, and half a pack of hot dog rolls were identified on the racks with no date to indicate when the items were pulled or needed to be used by. Five loaves of bread were dated with a sticker with the date March 8, in which Employee 14, indicated would be a pull date from the freezer. Employee 14 was not able to state why they were dated with March 8, when it was only March 7th. A produce cooler located on the lower level of the kitchen contained opened wire rack shelving in which food items were stored on the bottom shelves. There was no protective barrier to prevent the potential contamination from mop water splash or debris. A walk-in freezer had mixed vegetable spilled in several places on the floor and under shelving. A walk-in milk cooler on the lower level contained several crates of milk stored on top of plastic pallets on the floor of the cooler. The pallets contained openings to the floor. Dirt and debris were identified on the floor under the pallets and the floor edges against the pallets. Employee 14 stated she could not recall when and if the pallets are removed for cleaning under them. The dry storage room located on the lower level of the kitchen contained several open wire rack shelving units with food products. The bottom shelves did not contain any solid barrier to prevent the contamination of mop water splash or debris from sweeping. Some of the bottom shelves of the racks were observed to be only approximately three to four inches from the floor. Low metal food storage units throughout the center of the dry storage area contained a build-up of dust on the bases/legs of the units. The shelving unit where spaghetti sauce and tomato paste were stored contained cobwebs, and dust hanging from the shelf. A solid gray metal shelving unit containing baking powder, molasses, and pancake syrup had a peeling gray area and rust exposed on the shelving. Two bags of brownie mix were observed on a shelf with no date as to when they were placed there or when they needed used by. A wall in the main kitchen contained the storage of serving utensils, such as wire whisks,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395779	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTRE CREST	**502 EAST HOWARD STREET BELLEFONTE, PA 16823**

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 7) ladles, spoodles (solid and perforated serving spoons), tongs, etc. Employee 14 indicated staff would obtain the utensils from the wall and use them for preparation and serving, and they would not be re-washed before use. The utensils were exposed to the collection of dust and debris. Three of the ladles contained dust buildup and debris in the scoop portion of the ladle. An observation on March 7, 2020, at 2:22 PM on(NAME)Circle, revealed two three tier black carts parked in the hallway outside resident rooms. Both carts contained dust and debris on the shelves and indented areas of the handles. One of the carts contained dried splatter down the side of the cart. An unidentified staff member passing by stated the carts are used to pass water and collect dirty meal trays that were not collected on the kitchen cart. The staff member stated they are usually labeled as to which cart is for one of the other. Neither of the carts were labeled. Observation on March 7, 2020, at 11:10 AM in(NAME)Court pantry revealed that an open bag of peanuts, ketchup, and butter packets were in the cupboard. There were no use by dates on these items. Concurrent interview with Employee 21, nurse aide, confirmed the above. The surveyor reviewed the above findings with the Nursing Home Administrator and Employee 7, Interim Director of Nursing on March 8, 2020, at 1:30 PM. 483.60 (i) Food Procurement, Store/Prepare/Serve -Sanitary Previously cited deficiency 5/3/19 28 Pa. Code 211.6 (c)(d) Dietary services