STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395782	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAIRVIEW NURSING AND REHABILITATION CENTER	184 BETHLEHEM PIKE PHILADELPHIA, PA 19118

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** Based on resident and staff interviews, observation and review of facility documentation, it was determined that the facility failed to accomodate the needs of a resident related to replacing a mattress and wheelchair cushion for one of 53 residents interviewed (Resident R105). Findings include: Interview with Resident R105 on February 28, 2020 at approximately 10:00 a.m. revealed, I have lots of pain in my tailbone. I have it everyday but it is especially bad today. When asked if her bed was comfortable, Resident R105 stated, Oh no, look at it. I have to add these towels to the sunken area. When asked if her wheelchair cushion was comfortable Resident R105 stated, Oh no, my tailbone hurts when I sit too long. Observation on February 28, 2020 at 10:00 a.m. with Resident R105 revealed a stack of folded towels on the floor adjacent to the resident's bed. Continued observation revealed that Resident R105 picked up the towels and demonstrated the way she filled the sunken area with towels. At the time of the observation, the mattress appeared to have a significant concave, sunken area noted. Observation of the wheelchair cushion revealed that it was worn. Interview on February 28, 2020 at approximately 10:10 a.m. with Employee E16, Unit Manager, revealed she was unaware of the sunken area in Resident R105's mattress. The facility failed to accomodate the needs of and preferences of one resident related to replacing a mattress and a wheelchair cushion. 28 PA Code 211.10(d) Resident care policies 28 PA Code 211.12(d)(5) Nursing services
F 0572 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents a notice of rights, rules, services and charges.** Based on interviews with residents and facility staff, it was determined that the facility failed to ensure that residents admitted to the facility were provided with information about their rights as a resident in the facility, for seven of seven residents interviewed (Residents R1, R9, R11, R38, R79, R96 and R150). Findings include: During a group interview on March 2, 2020, at 11:00 a.m. with seven residents identified by the facility as being alert and oriented (Residents R1, R9, R11, R38, R79, R96 and R150), it was stated by all seven residents that they were not clear about their rights as residents of a long term care facility. Review of the last three months of Resident Council Minutes, dated December 10, 2019, January 14, 2020 and February 11, 2020, indicated no review of resident rights occurred during the meetings. Interview with Employee E14, Activities Director, on March 4, 2020, at 10:30 a.m. confirmed that she has not been reviewing any resident rights at the monthly Resident Council meeting. The facility did not ensure that residents were informed of their rights as residents of the facility as required. 28 Pa Code 201.29(n) Resident Rights
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and interviews with staff, it was determined that the facility failed to ensure that one of 53 residents reviewed, was provided the opportunity to execute an advanced directive as required (Resident R46). Findings include: A review of Resident R46's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, including but not limited to, [MEDICAL CONDITION] (damage or disease in the heart's major blood vessels), [MEDICAL CONDITION] (an irregular, often rapid heart rate) and muscle weakness. The resident was noted as moderately impaired in decision making skills. A review of Resident R46's POLST form (Physician order [REDACTED]. The POLST form was dated February 3, 2020, and indicated that the resident had requested that no CPR (Cardio-pulmonary resuscitation) was to be performed in the event of a medical emergency. Review of Resident R46's care plan, full code dated February 11, 2020, revealed that the resident requested to be a full code and wanted CPR (Cardio-pulmonary resuscitation- life sustaining interventions) in the event of a medical emergency. Interview with Employee E12, nurse on the second floor, on [DATE], at 10:00 a.m. confirmed that the clinical record contained conflicting information related to Resident R46's wishes for treatment in the event of a medical emergency . The facility failed to ensure that one resident was provided the opportunity to execute an advanced directive as required. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12 (d)(3) Nursing services 28 Pa. Code 211.12 (d)(5) Nursing services
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 observation, interview with residents and staff and review of facility policy and procedure, it was determined, the facility failed to ensure that information was readily available for residents and visitors/family, on how to file a grievance for seven of seven residents attending the group meeting, (Residents R1, R9, R11, R38, R79, R96 and R150). Findings include: Review of the facility policy and procedure, titled, Grievance Policy, undated, indicated, The facility will make information on how to file a grievance available to resident. During a Resident Council Interview, on March 2, 2020, at 11:00 a.m. with seven of seven residents identified by the facility as being alert and oriented, (Residents R1, R9, R11, R38, R79, R96 and R150), it was stated by all seven residents that they were not clear about the process and/or where information was posted on how to file a grievance with the facility. Observations of all three nursing units at various times during the survey on February 28 and March 2, 2020, revealed that information about filing a grievance was not displayed as required on the three of three nursing units. An observation was made of Employee E17, Regional Nursing Home Adminstrator, on March 3, 2020, at 1:15 p.m. posting information on the third floor nursing unit about filing a Grievance. At the time of the observation Employee E17, confirmed the grievance process was not readily available on all nursing units as required. Review of the grievance information that Employee E17, was posting, indicated, that the grievance official was Employee E18, Social Worker Director. During the interview Employee E17, Regional Nursing Home Adminstrator, was unaware, until it was brought to his attention by the surveyor, that Employee E17, Social Worker, who was identified as the grievance official, was not employed by the facility as a Social Worker. An interview with Employee E17, Regional Nursing Home Adminstrator, on March 3, 2020, at 1:45 p.m. confirmed grievance information was not posted on each of the three of three nursing units, as they should be. The facility failed to ensure information on how to file a grievance was readily available. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(3) Management 28 Pa Code 201.18(e)(1) Management 28 Pa Code 201.29(a)(d)(i) resident rights 28 Pa Code 211.5(f) Clinical records
F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Based on clinical record review, observation and resident and employee interviews, it was determined that the facility did not ensure that one of 38 residents reviewed was protected from misappropriation of personal property. (Resident R13) Finding included: A review of Resident R13's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, including but not limited to, [MEDICAL CONDITION] (an irregular, often rapid heart rate), [MEDICAL CONDITION] (damage or disease in the heart's major blood vessels) and muscle weakness. Additionally, the resident was noted with severe cognitive impairments related to decision making skills. A review of Resident R13's nurses note dated February 23, 2020, at 12:43 a.m. revealed that the resident asked this nurse to place his money in a secure place and will take it in the a.m The resident has $320.00 (16- twenty dollar bills in cash). The money was counted with the resident and witnessed by two nursing assistants and the charge nurse. House supervisor also notified. The money was then placed in middle medication cart in a locked narcotics box. Further review of Resident R13's clinical record revealed a nurse's note dated February 24, 2020, stated the resident is alert and oriented times two. He requires extensive assistance with one person with activity of daily living and transfers. The residents money ($320.00) secured in second floor middle cart narcotics box per the resident's request. Further review of nurse's notes revealed no documentation regarding the residents' money. Interview with Resident R13 on March 3, 2020 at 2:00 p.m. revealed the resident did not want to talk about his money with the surveyor. An interview with Employee E13, a nurse on the second floor, on March 3, 2020, at 2:45 p.m. on the middle cart, did open the locked narcotic box and the residents' money was not in the box. Employee E13 spoke with the second floor unit manage at that time and the unit manager stated that she believed that the money was taken down to the business office. Further interview with Employee E13 at the above time, revealed a paper in the narcotics book that documented on February 25, 2020, four nurse's signed that there was $300.00 dollars in the locked narcotics box. The next entry was February 29, 2020, a nurse signed on the 7:00 p.m. shift and documented that there was no money in the cart. No other documentation was available for review related to the whereabouts of the residents money. During an interview on March 3, 2020, at 2:00 p.m. with the Nursing Home Administrator, it was requested that the administrator provide documentation of the amount and the location of Resident R13's money. The Nursing Home Administrator did not provide any additional documentation related to the amount and location of Resident R13's money as requested. 28 Pa. Code 201.18 (b)(2) Management 28 Pa. Code 211.12 (d)(3) Nursing services
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility policies and procedures, facility documentation and interviews with staff, it was determined that the facility failed to conduct a complete and thorough investigation into an allegation of misappropriation of resident property for one of 53 residents reviewed (Resident R137). Findings include: Review of an undated facility policy, Abuse Prohibition and Investigation, revealed that the facility was responsible to ensure that each resident was free from misappropriation of resident's property. The policy further indicated that all reports of misappropriation of resident property must be reported to the administrator and director of nursing immediately. Additionally, the policy indicated that the facility would conduct a thorough investigate into any observations, complaints or evidence of alleged misappropriation of resident property. Review of facility policy, Receipt of Routine Deliveries, undated, indicated that the facility received medications from an outside pharmacy. The policy further indicated that upon receipt of medications, the licensed nurse was to sign for the medication delivery and the date and the time of arrival, then take responsibility for the receipt from the pharmacy. Review of an undated facility policy, Controlled Drug Shift Audit, revealed that the total count of medications and number of cards was to be completed and documented by the on-coming and off-going licensed nurse at the start of each shift. Clinical record review for Resident R137 indicated that the physician had ordered the pain medication [MEDICATION NAME] (opioid type narcotic [MEDICATION NAME]) 15 milligrams 1 tablet by mouth every six hours as needed for severe pain during the month of October, 2019. Review of information submitted by the facility, dated October 20, 2019, indicated that a total of 30 tablets of [MEDICATION NAME] had been misappropriated from Resident R137. Review of information submitted by the facility identified three employees who were responsible for the safe keeping of Resident R137 medications on October 19 and 20, 2019. Further review of the information submitted by the facility revealed no additonal documentation available for review to indicate that the facility had done a complete and thorough investigation into the missing medications. Interview with the Director of Nursing and the Administrator on March 2, 2020, at 2:00 p.m., confirmed that the facility had identified three nursing staff members Employee E28, E29, and E30, as the perpetrators for the suspected theft of resident property. Further during interview the Director of Nursing and the Administrator further confirmed that the facility had failed to conduct a complete and thorough investigation into the missing narcotic pain medications on October 19 and 20, 2019 for Resident R137. The facility failed to conduct a complete and thorough investigation into the deliberate misplacement of resident property. 28 Pa. Code 211.9(a) Pharmacy services 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(c) Nursing services 28 Pa Code 211.12(d)(1) Nursing services 28 Pa Code 211.12(d)(5) Nursing services
F 0646 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the appropriate authorities when residents with MD or ID services has a significant change in condition.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure that one resident with a diagnosed mental disorder was referred for a Level II PASSR (Pre-Admission Screening and Resident Review) review as required for one of 53 resident records reviewed (Resident R59). Findings include: The PASSR was created in 1987 through language in the Omnibus Budget Reconciliation Act (OBRA) and it has three goals: to identify individuals with mental illness and/or intellectual disability, to ensure they are placed appropriately, whether in the community or in a nursing facility, and to ensure they receive the services they require for their mental illness intellectual disability. The PASSR Level I must be completed on all persons who are considering admission to a Medicaid certified nursing facility. A Level II PASSR evaluation must be completed if the Level I PASSR determined that the person is a targeted person with mental illness or an intellectual disability. The Level II PASSR would determine if placement or continued staying the current nursing facility is appropriate. Review of Resident 59's significant change Minimum Data Set (MDS-mandated standardized tool completed at specific intervals to determine resident care needs) assessment dated [DATE],/2019 revealed that the resident had a significant change in condition which necessitated an inpatient stay at a psychiatric hospital. Further review of Resident R59's clinical record revealed no documented evidence that the facility forwarded the initial PA-PASRR form and/or completed the necessary forms to alert the appropriate agencies of Resident 59's serious mental illness and significant change in condition. Interview conducted during the afternoon on March 4, 2020, with the Administrator, confirmed that the facility had not notified the state mental health authority and/or the state intellectual disability authority was not promptly notified of Resident R59's significant change in condition, as required. The facility failed to notify appropriate authorities regarding a significant change in condition for one resident. 28 Pa Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(5) Nursing services
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record review and interviews with residents and staff, it was determined that the facility failed to ensure that a baseline care plan related to discharge planning needs was developed within 48 hours for one of 38 residents reviewed (Resident R407). Findings include: Review of facility policy, Care Plans -Baseline dated revised December 2016, revealed that A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. Continued review revealed that The interdisciplinary Team will review the healthcare practitioner's orders and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: Initial goals based on admission orders [REDACTED]. Interview on February 28, 2020, at 9:28 a.m. with Resident R407 revealed that he just arrived at the facility on Monday (February 24, 2020) and was here for a short term stay to receive wound care. Review of Resident R407's Admission Social History assessment dated [DATE], revealed that the resident's projected length of stay was short term, that the resident was

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F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) motivated to get better and go back to the community, and that the resident's current living situation was homeless. Review of a social services note dated February 25, 2020, at 11:48 a.m. revealed that Resident R407's goals were to get better and discharge back to the community. The note also indicated that the resident was homeless and has no where to go. The note further indicated that the resident's disposition was uncertain at this time due to his homelessness. Review of Resident R407's baseline care plan dated initiated February 24, 2020, revealed that there was no plan developed related to discharge planning. Interview on March 4, 2020, at 9:17 a.m., with Employee E10, Social Worker, revealed that no discharge care plan had been developed because the social worker was waiting for the care plan meeting. Employee E10 further indicated that the care plan meeting had not been scheduled. Employee E10 further confirmed that no interventions had been put in place to address the resident's homelessness and desire to return to the community. The facility failed to ensure that a baseline care plan was developed within 48 hours for a short-term resident's discharge planning needs. 28 Pa Code 211.11(b) Resident care plan
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and interviews with residents and staff, it was determined that the facility failed to develop a comprehensive person-centered care plan related to smoking for one of two residents reviewed who smoke (Resident R54). Finding include: Observation of the scheduled smoke break on February 28, 2020, at 9:21 a.m. revealed that all smokers obtained their supplies from a lock box, went outside to an enclosed patio area and received supervision from Employee E11, medical records staff. Interview with Employee E11, at the time of the observation, revealed that all residents are required to keep their supplies locked in a box kept at the front desk and be supervised while smoking. Interview with Resident R54 on February 28, 2020, at 10:16 a.m. confirmed that the resident goes outside during scheduled smoke breaks. Review of Resident R54's Quarterly Smoking Safety Screen dated January 15, 2020, revealed that the resident smokes five to ten cigarettes per day and likes to smoke in the morning, afternoon, evening and night. Continued review of the safety screen revealed that the resident requires supervision for smoking and for the facility to hold all cigarettes and lighters to assure safe smoking. Review of Resident R54's care plan dated initiated October 17, 2019, revealed that the resident was admitted to the facility on [DATE]. Continued review of the care plan revealed that there was no documentation or plan developed related to the resident's cigarette smoking. Interview with Employee E4, licensed practical nurse, on March 3, 2020, at 1:50 p.m., revealed that the employee did not add smoking to Resident R54's care pan because he rarely goes out to smoke. The facility failed to develop a comprehensive person-centered care plan related to smoking. 42 CFR 483.21(b) Comprehensive Care Plans 28 Pa. Code 211.11(b) Resident care plan
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 review of clinical records, observation and interviews with staff and residents, it was determined that the facility failed to provide the necessary care and services to maintain activities of daily living related to ambulation for one of 53 residents reviewed (Resident R60). Findings include: Observation of Resident R60 on February 28, 2020 at 10:40 a.m., and on March 2, 2020 at 11:00 a.m., revealed that the resident was seated in a wheelchair. Resident R60 was further observed using the wheelchair to ambulate inside the bedroom. Interview with Resident R60 at 10:40 a.m., on February 28, 2020 revealed that the resident was using the wheelchair regularly. Further interview with Resident R60 revealed that the resident felt that she would need assistance to walk. Review of Resident R60's annual Minimum Data Set (MDS- assessment of care needs) dated October 8, 2019 and quarterly assessment dated [DATE], indicated that Resident R60 had moderately impaired cognition (poor decision making ability). The assessments also indicated that Resident R60 required supervision and assist of one staff member with transfers (how resident moves between surfaces including to or from bed, chair, wheelchair and standing position) and that Resident R60 required supervision for walking. Review of the clinical record for Resident R60 indicated that the physical therapist had evaluated the resident on December 26, 2019 through Janaury 21, 2020. The physical therapist assessed Resident R60 with the ability to ambulate safely on level surfaces 25 feet with care giver assistance. The physical therapist discussed Resident R60's current level of function with the nursing staff and developed a restorative nursing program care plan for mobility that included walking Resident R60 with nursing supervision and care giver assistance for a distance of 10 to 49 feet routinely. Further review of Resident R60's clinical record revealed no documentation available for review to indicate that staff were ambulating (walking) Resident R60 on a routine basis for January, February or March, 2020. Interview with Employee E4, licensed practical nurse, on February 28, 2020 at 1:00 p.m., confirmed that that the facility had no documentation available for review that Resident R60 was on a restorative nursing program and received the activity of walking with staff, as therapy recommended, during the months of January, February and March, 2020. The facility failed to ensure that each resident received care and services to ensure activities of daily living for mobility, including walking were maintained. 28 Pa Code 211.12(d)(1) Nursing Services 28 Pa Code 211.12 (d)(5) Nursing services 28 Pa. Code: 211.11(a)(b) Resident care plan
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records, review of facility policies and interviews with staff, it was determined that the facility failed to obtain and/or clarify physicians orders related to medication administration and [MEDICAL TREATMENT] treatments for three of 38 residents reviewed (Resident R103, R134 and R137). Findings include: Review of facility policy titled, Physician Services, dated April 2013, revealed, Physician orders [REDACTED]. Review of facility policy, Pain Assessment and Management, dated March 2015, indicated, The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs that address the underlying causes of pain. The staff were to monitor for effectiveness of interventions, modify approaches as necessary, assess the intensity of the pain and describe the origin and cause of the resident's pain. Review of Resident R103's current physician's orders [REDACTED]. One order dated January 13, 2020, was for [MEDICATION NAME] 325 mg (milligrams) give two tablets by mouth as needed for mild pain. The second order was dated January 26, 2020, for [MEDICATION NAME] 325 mg give two tablets by mouth every six hours as needed for mild pain scale one to four, no more than three grams per day, if pain persists or worsens notify a physician. Interview on March 3, 2020, at 11:59 a.m., with Employee E4, licensed practical nurse, confirmed that Resident R103 had duplicate orders for Tylenol. Interview with Employee E19, licensed nurse, on February 28, 2020, at 11:00 a.m. revealed that Resident R134 received [MEDICAL TREATMENT] (a blood purifying treatment given when kidney function is not optimum) treatments three days a week. Review of Resident R134's clinical record revealed that the resident was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. Continued review of the clinical record revealed that at the time of the resident's admission into the facility he was receiving [MEDICAL TREATMENT] services. Further interview with Employee E19, licensed nurse, on March 3, 2020 at 9:40 a.m., confirmed that there was no current physician's orders [REDACTED]. Review of Resident R137's quarterly Minimum Data Set(MDS-an assessment of care needs) dated November 25, 2019 and February 7, 2020, revealed that the resident was cognitively intact. Clinical record review for Resident R137 revealed physician's orders [REDACTED]. Additionally, Resident R137 had physician's orders [REDACTED]. The pain level for the [MEDICATION NAME] was not indicated in the physician's orders [REDACTED]. The nursing staff were documenting on these dates that the administration of this medication was for mild or moderate pain. Interview with Employee E4, licensed practical nurse, on March 3, 2020 at 9:00 a.m., revealed that severe pain was categorized at a level of 7, 8, 9 or 10, on a scale from 1 - 10. Interview with Employee E27, licensed practical nurse, on March 3, 2020 at 9:00 a.m., confirmed that the nursing staff failed to administer pain medication for Resident R137 in accordance with physician's orders [REDACTED]. Employee E27 also confirmed that the nursing staff failed to clarify the orders for [MEDICATION NAME] and obtain from the the physician the pain level indicated for administration

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) of the medication. The facility failed obtain, clarify and follow physician orders [REDACTED]. 42 CFR 483.25 Quality of Care 28 Pa Code 211.9 Pharmacy services 28 Pa Code 211.12 (d)(1) Nursing services 28 Pa Code 211.12 (d)(5) Nursing services 28 Pa Code 201.18 (b)(1) Management
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Based on observation, review of clinical records, facility documentation and interviews with residents and staff, it was determined that the facility failed to maintain a hazard free environment one of three nursing units. (3rd floor nursing unit) Findings include: Tour of the 3rd floor nursing unit on February 28, 2020, at 11:19 a.m. revealed in Resident R5's room a four ounce bottle of cold flu medicine on the bureau. Interview with Employee E19, licensed nurse, on February 28, 2019, at 11:25 a.m. confirmed the presence of the four ounce bottle of liquid cold/ flu medicine, sitting on Resident R5's bureau. Employee E19 further confirmed that the bottle was half full containing approximately two ounces of a green colored liquid. Continued interview with Employee E19, revealed that Resident R5, had severe cognitively impaired and ambulated independently. Employee E19 further indicated, that the bottle of medication, was not one that the facility uses and was not sure where the bottle came from. Continued observation of Resident R5's room revealed Employee E19, pulled down an empty cardboard box from the top of the dresser cabinet and two blue disposal razors fell out. Employee E19 stated, These should not be up there. Continued initial tour of the Third floor nursing unit, revealed an observation of Resident R48's room, at 11:50 a.m. which revealed a 75 ounce bottle of Tide laundry detergent, sitting on the floor in the corner, between the bed and bedside table. An interview with Employee E19, at 12:10 p.m. indicated that Resident R48, Should not have this as she picked it up off the floor. At the time of the observation and interview with Employee E19, she indicated, that Resident R48, has one roommate, that was identified as somewhat confused and another that was severely impaired, and both were able to ambulate independently. A follow up interview with Employee E19, on March 2, 2020, at 1:30 p.m. revealed that the Third floor nursing unit, has 31 residents that are identified as being somewhat and/or severely impaired cognitively. Employee E19, further indicated, of the 31 residents that are identified as being impaired cognitively, 15 of the residents, ambulate independently around the nursing unit, that could have independently accessed the liquid cold flu medicine and/or laundry detergent. The facility failed to ensure that the Third floor nursing unit was free of accident hazards related to an over the counter cold/flu medicine and a laundry detergent left at the reach of 15 cognitive impaired and ambulatory residents. During a Resident Council Interview, on March 2, 2020, at 11:00 a.m. with seven of seven residents identified by the facility as being alert and oriented, one Resident R9, indicated, that her heater in her room was not working. Observation of Resident R9's room, after the Resident Council Interview, at approximately, 12:20 p.m. revealed an orange extension cord was plugged into a portable air conditioning (ac)/heater unit, which was observed to be running along the length of the wall, behind two bureaus, a cross from the foot of Resident R9's bed, which was then plugged into the portable ac/heating unit. An interview and observation with Employee E15, Maintenance Director, on March 2, 2020, at 12:15 p.m. revealed the extension cord was needed in order for the portable ac/heater to work. Employee E15, indicated the outlet was across the room so an extension cord was required. At the time of the observation and interview with Employee E15, he indicated the extension cord was 25 feet long. An interview with the Nursing Home Administrator and Regional Nursing Home Administrator, at 2:50 p.m. on the same day, indicated, not being aware that Resident R9's v-tec unit, (window ac/heater unit), was not working and that a portable ac/heater was being used by the use of an extension cord was 25 feet long. Nursing Home Administrator also indicated being unaware that extension cords were not allowed to be used in a nursing facility. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(a)(b)(1)(3) Management 28 Pa Code 211.12(d)(1) Nursing Services 28 Pa Code 211.12 (d)(5) Nursing services
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of the dietary manual and facility menus, observation of meal service and interviews with staff and residents, it was determined that the facility failed to ensure that one of 53 residents reviewed maintained acceptable parameters of nutritional status related to body weight (Resident R29). Findings include: Review of the quarterly Minimum Data Set (MDS- assessment of care needs) dated September 27, 2019, indicated that Resident R29 had a [DIAGNOSES REDACTED]. The assessment also indicated that the resident was cognitively intact and that the resident was not on a physician prescribed weight-loss regime. Clinical record review for Resident R29 revealed that the physician had ordered a regular diet for the resident. Continued review of the clinical record revealed the resident's weight was recorded as 181 pounds on October, 27, 2019 and 170 pounds on November 14, 2019. This reflected a weight loss of eleven pounds in one month and represented a significant weight loss (5% loss in thirty days) Interview with Resident R29 on February 28, 2020, at 1:00 p.m., revealed that the resident had not been eating well. The resident reported that she found the food items repetitive and wished there was more variety. Resident R29 reported that she does not like fish and that every time fish was offered on the facility menus she would be given a ground beef patty (hamburger on a bun). The resident reported that she was tired of ground beef patties on a bun. Resident R29 also reported that she had reported her food preferences to the facility staff many times, since her admission on April 8, 2019. Additionally, the resident reported to the facility that she had a lactose intolerance (the inability to digest lactose or milk sugar). Observation of Resident R29 on March 3 and 4, 2020 revealed that the resident received the same breakfast foods daily (milk, banana and cold cereal). The resident had requested to have traditional breakfast meats (bacon or scrapple) two days a week. The resident further requested that a breakfast Danish or muffin be included into her breakfast meal once a week. Interview with Employee E25, director of dietary services, on March 3, 2020, at 9:30 a.m., revealed that the facility does have bacon available daily for breakfast meals, to accommodate the resident's food preferences. Further interview with the director of dietary services revealed that the resident's meals were not being prepared with lactose free milk. A review of the facility's therapeutic diets and menus indicated that there were no menus or therapeutic diets preplanned for Resident R29, related to the resident's lactose intolerance. Interview with Employee E26, registered dietitian, on March 3, 2020, at 9:45 a.m., confirmed that the facility's dietary manual did not include any preplanned therapeutic diets for residents on a low lactose diet. The registered dietitian also confirmed that the facility menus did not include a low lactose diet. The facility failed to ensure that one resident maintained acceptable parameters of nutritional status related to body weight. 28 Pa. Code: 211.6(d) Dietary services 28 Pa Code 211.12(d)(1) Nursing Services 28 Pa Code 211.12 (d)(5) Nursing services
F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, information submitted by the facility, observations of care and services and interviews with residents and staff, it was determined that the facility failed to ensure that one of fifty-three residents observed received appropriate behavioral heath care (Resident R109). Findings include: Observation of Resident R109 on February 28, 2020, from 11:00 a.m. until 12:00 p.m., revealed the resident was yelling out with outbursts of profanity, while residents were sitting in the hallway near the nursing station, staff were trying to perform nursing duties and distribute meal trays and visitors were speaking with staff behind the nurses station. Resident R109 observed being verbally aggressive forming a fist with his hand and punching his other hand, while ambulating around the nurses station toward the nursing staff. The resident was heard yelling I want my money and if you don't give me my money I am going to knock you out. Employee E4, licensed practical nurse, was observed trying to redirect the resident's behavioral outbursts and threats to harm the staff. The licensed nurse stated that he won't hurt you, don't worry. Review of the clinical record for Resident R109 review revealed no documentation that Resident R109 exhibited physical and/or verbal behavioral symptoms directed toward others. Review of the quarterly Minimum Data Set (MDS- assessment of resident care needs) dated September 27, 2019 indicated that Resident R29 was cognitively intact. Interview with Resident R29 on February 28, 2020, at 11:45 a.m., revealed that Resident R109 behaves this way routinely. Resident R29 said that it was irritating and annoying and that it really bothers her when she was trying to sleep at 5:00 a.m., and 6:00 a.m., and he begins yelling out obscenities. Interview with seven alert and oriented resident council members (Residents R96, R38, R150, R79, R1, R9 and R11), on March

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy, clinical record review and interviews with staff, it was determined that the facility failed to ensure that one of five residents who received an antipsychotic medication (medications used to treat certain mental health conditions) were reviewed for appropriate drug therapy and gradual dose reduction.(Resident R103). Findings include: Review of facility policy, [MEDICAL CONDITION] Drug Use undated, revealed that, Based on a comprehensive assessment and only if necessary to treat a specific condition, the customer may be ordered a [MEDICAL CONDITION] drug. Continued review revealed that [MEDICAL CONDITION] medications may be appropriate to treat conditions such as dementia only when there are associated agitated states which are quantitatively and objectively documented and which are persistent and are not due to preventable reasons and which constitute sources of distress or dysfunction to the customer or represent a danger to the customer or others. Continued review revealed, Antipsychotic's are not to be used if one or more of the following is/are the only indication: . impaired memory . depression (without psychotic features). Further review revealed that, If an antipsychotic drug is used in the absence of a [DIAGNOSES REDACTED]. Review of Resident R103's March 2020 physician's orders [REDACTED]. Continued review revealed that the resident also receives [MEDICATION NAME] (an antidepressant) 30 mg at bedtime for depression. Review of Resident R103's care plan, dated initiated September 11, 2019, revealed that the resident was admitted to the facility on [DATE], and had [DIAGNOSES REDACTED]. (a progressive disorder of the nervous system that affects movement), [MEDICAL CONDITION] (a progressive disease that destroys memory and other important mental functions), and depression (mood disorder characterized by low mood, a feeling of sadness, and a general loss of interest in things). Continued review of Resident R103's care plan revealed that the resident receives a [MEDICAL CONDITION] medication for management of dementia with behavioral disturbances with interventions for psych consults and review for gradual dose reduction as per facility policy. Continued review of the care plan revealed that there were no behaviors documented that indicated the need for a [MEDICAL CONDITION] or antipsychotic medication. Observation on February 28, 2020, at 1:49 p.m. revealed Resident R103 quietly and contently sitting in the hallway in a highback wheelchair. Continued observation on March 3, 2020, at 9:17 a.m. revealed that the resident was quietly resting in bed and needed continence care to be provided. The resident was completely dependent on staff to both anticipate and provide for all of his care needs. Review of progress notes revealed that there was no documentation which indicated that the resident exhibited any behaviors that would necessitate the continued need for [MEDICAL CONDITION] or antipsychotic medication. Continued record review revealed that there were no psychiatric consults or gradual dose reduction reviews available for review. Interview on March 3, 2020, at 11:59 a.m. Employee E4, licensed practical nurse, confirmed that Resident R103 had not been seen by a psychiatrist or psychologist (mental health providers) since his admission to the facility. Employee E4 also confirmed that the resident has not had any behaviors or reviews for [MEDICAL CONDITION] medications. Employee E4 stated that the facility's last meeting for gradual dose reduction was in December 2019, and that she usually pulls residents who are experiencing behaviors for review. Employee E4 further stated that she has not had Resident R103 reviewed for a gradual dose reduction or seen by a psychiatrist or psychologist because he had not had any behaviors. The facility failed to ensure that one resident who received an antipsychotic was reviewed for appropriate drug therapy and gradual dose reduction. 28 Pa Code 211.9(k) Pharmacy services
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility policy and staff interview, it was determined that the facility failed to maintain complete and accurate clinical documentation related to monitoring/check of a resident when in bed (Resident R47) and medication administration for two of 38 residents reviewed. (Resident R47 and Resident R134) Findings include: Clinical record review for Resident R47, revealed a physician's orders [REDACTED]. Further review of Resident R47's clinical record revealed facility documentation, titled, Morse Falls Scale, (an assessment tool - to determine ones fall risk factors and target interventions to reduce risks), dated, May 9, 2019, identified the resident at high risk of falls. Continued review of Resident R47's clinical record revealed an initial fall care plan developed, on November 8, 2018, which indicated, Resident R47, was a risk for falls and fall measures were in place, such as maintaining a clutter free environment and insuring Resident R47, was wearing proper foot wear. Review of nursing notes dated, August 28, 2019, revealed that Resident R47 sustained a fall from bed. Review of fall care plan up-dated, August 28, 2019, indicated a safety measure for nursing staff to complete for Resident R47 1 hour monitoring/check when in bed. Further review of nursing notes dated November 15, 2019, revealed that Resident R47 sustained a fall from bed. Review of Resident R47's

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) January 2020 physician's orders [REDACTED]. An interview with Employee E19, Licensed nurse, on March 3, 2020, at 11:45 a.m. confirmed that there was no documentation that 1 hour monitoring/check when in bed was completed by the nursing staff. Review of nursing progress notes dated February 21, 2020, revealed that the resident sustained [REDACTED]. Review of facility documentation titled, Certified Nurse Aide Care Tracker, (documentation signed by nurse aide) from January and February 2020 indicating 1 hour monitoring/check when in bed revealed that there was no documentation that the 1 hour checks were completed by the nursing assistants. Review of facility policy, Pain Assessment and Management, dated March 2015, indicated, The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs that address the underlying causes of pain. The staff were to monitor for effectiveness of interventions, modify approaches as necessary, assess the intensity of the pain and describe the origin and cause of the resident's pain. Review of the clinical record for Resident R134, revealed diagnoses, including but not limited to, Stage II pressure ulcer (localized injuries to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.) of the left heel, non-pressure chronic ulcer of unspecified part of lower leg, (diseases of the skin and subcutaneous tissue, other disorders of the skin and subcutaneous tissue) and [MEDICAL CONDITION], ([MEDICAL CONDITION] - poor circulation of the extremities). Review of Resident R134's October 2019 physician orders [REDACTED]. Review of Resident R134's October 2019 Medication Administration Record (MAR) revealed that on October 24, 25, 26, 27 and 28, 2019, Resident R134 was administered [MEDICATION NAME] 5 mg, two tablets by mouth for severe pain. Continued review of the October 2019, MAR for the dates that the [MEDICATION NAME] was administered did include any documentation of Resident R134's pain level at the time the [MEDICATION NAME] was administered. Review of Resident R134's November 2019 MAR, revealed that on November 3,5, 7, 10, 11, 13, 14, 15, 22, 25, 26, 28 and 30, 2019, the resident was administered [MEDICATION NAME] 5 mg, two tablets, by mouth for severe pain. There was no documented evidence on the MAR and/or in nursing progress notes for the above stated dates related to Resident R134's pain level at the time of the administration of the [MEDICATION NAME]. Review of Resident R134's December 2019 MAR, revealed that on December 7, 8, 14 and 28, Resident R134, received [MEDICATION NAME], 5 mgs two tablets, by mouth. for severe pain. There was no indication on the MAR and/or in nursing progress notes related to Resident R134's pain level at the time of the administration of the [MEDICATION NAME]. Continued review of Resident R134's December 2019 MAR, revealed an order dated December 2, 2019, for Tylenol with [MEDICATION NAME] #3, (an opioid pain medication), 1 tablet by mouth, every four hours as needed for pain, with a hand written note indicating, moderate pain. Additional review of the December MAR revealed that Resident R134 had received Tylenol [MEDICATION NAME] #3 on December 5, 8 and 10, 2019. Further review of the MAR and nursing progress notes did not revealed any documentation of the resident's pain level at the time the Tylenol [MEDICATION NAME] #3, was administered. Review of Resident R134's January 2020 MAR indicated the administration of [MEDICATION NAME] 5 mg on January 1, twice on the 4th, 15, 21, four times on the 30th and twice on the 31st, Further review of the January MAR and nursing progress notes revealed no documentation of what R134's pain level was at the time of the admistration of the medication. Continued review of Resident R134's January 2020 Medication Administration Record, revealed an order dated January 29, 2020, to receive [MEDICATION NAME] 5 mg, two tabs, orally, every 6 hours, as needed for break through pain. Continued review of the February 2020, MAR, indicated that Resident R134 ha received the medication on February 8, for a indicated pain level of 4, February 10, 11, 12 and 13, for an indicated pain level of 8. February 16, for a pain level indicated, 6, February 17, 7, February 21, 8, February 25, 6, and February 27, 8. Review of March, 2020, MAR, for March 3, 2020, indicated a pain level of 8. Interview with Employee E19, Licensed nurse, on March 3, 2020, at 12:05 p.m. revealed that, Break through pain level would be a 10, on a scale 0 - 10. Employee E19, further indicated that R134's pain level as documented on dates pain medication was administered, was not an appropriate pain level indicated to receive the pain medication. The facility failed to maintain complete and accurate clinical documentation for two residents. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1) Nursing services 28 PA. Code 211.12(d)(5) Nursing services
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on review of professional literature, review of facility policies, review of facility documentation and interviews with staff, it was determined that the facility failed to maintain an effective infection prevention and control program (IPCP). Findings include: Review of facility policy, Infection Prevention and Control Program dated revised August 2016, revealed, The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection and employee health and safety. Continued review revealed that Immunization is a form of primary prevention. Widespread use of influenza vaccine in the nursing facility is strongly encouraged. Review of facility policy, Infection Prevention and Control Committee dated revised July 2016, revealed that duties of the Committee include: assist in the development and implementation of written policies and procedures for the prevention and control of infectious or communicable diseases within the facility; disseminate current information on health practices to all employees; assist in developing and implementing the written policies and procedures to identify and address infections within the facility; establish and monitor the facility Antibiotic Stewardship Program; maintain written accounts of meetings conducted and action taken by the committee (minutes of meetings); help assure that sufficient inventory of personal protective equipment (gowns, gloves, masks) is on hand and readily accessible; and maintain access to current CDC guidelines and recommendations relative to infection control issues in healthcare facilities. Review of the Centers for Disease Control and Prevention (CDC) website, Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 (Coronavirus) in the United States dated last reviewed February 29, 2020, revealed special considerations that long term care facilities should take, including limiting visitors, posting signs on hand hygiene, respiratory hygiene and cough etiquette, ensuring supplies are available, taking steps to prevent known or suspected COVID-19 patients from exposing other patients, identify dedicated staff to care for infected patients and observe newly arriving patients for the development of respiratory symptoms. Review of the facility's Infection Control binder revealed logs for tracking the use of antibiotics, catheters and intravenous therapies in the facility. Continued review revealed quarterly committee sign-in sheets; however, there was no indication that a representative from pharmacy, laboratory or maintenance (safety officer) attended the last three meetings. Additionally, there were no meeting minutes available for review at the time of the survey. Interview with Employee E5, infection control nurse, on March 4, 2020, at 11:11 a.m. revealed that the facility did not take minutes during committee meetings and that there were none available for review. Employee E5 stated that during meetings tracking for antibiotics, catheters and intravenous therapies are reviewed. Continued interview revealed that there was no data analysis or input from the pharmacist or laboratory departments; no analysis or feedback to physicians related to antibiotic usage; no tracking of residents who have potential signs of infection but who are not on antibiotics; no tracking of residents who received Influenza or pneumococcal vaccinations; no emergency preparedness plans for outbreaks including no planning for the prevention and management of the novel coronavirus; no inventory monitoring of personal protective equipment; no monitoring of environmental services cleaning habits or inventory of soaps and hand sanitizing products; and no monitoring of employee health. Interview with the Director of Nursing (DON) on March 4, 2020, at 1:36 a.m., confirmed that there were no Infection Committee minutes available for review. Review of the facility's Antibiotic Use Tracking Sheet for February 2020 revealed that three residents were prescribed oral antibiotics without a specified duration. Continued interview with the DON confirmed this finding and revealed that she could not explain why there was no specified duration. The facility failed to maintain an effective antibiotic stewardship program. Review of clinical records for three residents revealed that there was no documentation in their records available at the time of review to indicate that they were offered or screened for the Influenza and/or Pneumococcal vaccines. Interview with Employee E5, infection control nurse, on March 3, 2020, at 12:16 p.m. confirmed the findings listed above. Additionally, the facility was unable to provide policies specifically related to Influenza and Pneumococcal vaccines at the time of the survey. The facility failed to ensure that residents were offered Influenza and Pneumococcal vaccinations as required. The facility failed to maintain an effective infection prevention and control program. Refer to F881 Refer to F883 28 Pa Code 201.18(b)(1) Management
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to maintain an effective antibiotic stewardship program for three of three residents reviewed on antibiotic therapy (Residents R407, R99 and R101). Findings include: Review of facility policy, Infection Prevention and Control Program dated revised August 2016, revealed that, The infection prevention and control committee is responsible for reviewing and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) providing feedback on the overall program . Some examples of committee reviews may include: whether physician management of infections is optimal, whether antibiotic usage patterns need to be changed because of development of the resistant strains, whether information about cultures results or antibiotic resistance is transmitted accurately and in a timely fashions and whether there is appropriate follow-up of acute infections. Review of facility policy, Antibiotic Stewardship dated revised December 2016, revealed that if an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements: drug name, dose, frequency of administration, duration of treatment, start and stop date or number of days of therapy, route of administration and indications for use. Review of physician's orders [REDACTED]. There was no end date or duration of treatment indicated in the physician's orders [REDACTED]. Employee E4 stated that she was unsure when the resident was scheduled to attend his follow up appointment. Review of the facility's Antibiotic Use Tracking Sheet for February 2020 revealed that three residents (Residents R407, R99 and R101) were prescribed oral antibiotics without a specified duration. Continued review of the Antibiotic Use Tracking Sheet for Resident R407 revealed that there were no type of infection, no diagnostic tools, no identified organisms, no signs or symptoms or other contributing factors documented. Continued review of the Antibiotic Use Tracking Sheet revealed that for Resident R99 there were no diagnostic tools used, no identified organisms, no signs or symptoms or other contributing factors. There was no documentation on the tracking sheet to indicate why the resident needed the antibiotic other than for [MEDICATION NAME]. Review of Resident R99's physician orders [REDACTED]. There no end date or duration of treatment indicated in the order. Review of Resident R101's physician orders [REDACTED]. There was no end date or duration of treatment indicated in the order. Interview with Employee 5, Infection Control Nurse, on March 4, 2020, at 11:11 a.m. revealed that it was the responsibility of the physician to review and monitor residents who are on antibiotics. Employee E5 was unable to explain why Residents R407, R99 and R101 did not have a specified duration for their antibiotic therapy or why Resident R99 needed [MEDICATION NAME] antibiotics for over two months. Interview with the Director of Nursing on March 4, 2020, at 1:36 p.m. confirmed and could not explain why Residents R407, R99 and R101 did not have a specified duration for their antibiotic therapy or why Resident R99 needed [MEDICATION NAME] antibiotics. The facility failed to maintain an effective antibiotic stewardship program. 28 Pa Code 201.18(b)(1) Management
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that residents were offered Influenza and Pneumococcal vaccinations as required for three of five residents reviewed. (Residents R53, R153 and R126). Findings include: Review of facility policy, Infection Prevention and Control Program dated revised August 2016, revealed that Immunization is a form of primary prevention. Widespread use of influenza vaccine in the nursing facility is strongly encouraged. Policies and procedures for immunization include the following: the process for administering the vaccines; who should be vaccinated; contraindications to vaccinations; potential facility liability and release from liability; obtaining direct and proxy consent, and how often; monitoring for side effects of vaccination; and availability of the vaccine, and who pays for it. Review of physician's orders [REDACTED]. Continued review of the clinical record for Resident R153 revealed that there was no documentation in the record available at the time of review to indicate that the resident was offered or screened for the Pneumococcal vaccine. Review of physician's orders [REDACTED]. Continued review of the clinical record for Resident R126 revealed that there was no documentation in the record available at the time of review to indicate that the resident was offered or screened for both the Influenza and Pneumococcal vaccines. Review of physician's orders [REDACTED]. Continued review of the clinical record for Resident R53 revealed that there was no documentation in the record available at the time of review to indicate that the resident was offered or screened for both the Influenza and Pneumococcal vaccines. Interview on March 3, 2020, at 12:16 p.m. Employee E5, infection control nurse, confirmed that there was no documentation available to indicate that the Influenza vaccine was offered to Residents R126 and R53, and that Pneumococcal vaccines were offered to Residents R153, R126 and R53. Continued interview with Employee E5 revealed that all residents should be screened and offered both the Influenza and Pneumococcal vaccines. The facility failed to ensure that residents were offered Influenza and Pneumococcal vaccinations as required. 28 Pa Code 201.18(b)(1) Management