STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395382	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GROVE AT NORTH HUNTINGDON, THE	249 MAUS DRIVE NORTH HUNTINGDON, PA 15642

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** Based on clinical record reviews and resident and staff interviews, it was determined that the facility failed to ensure that residents were provided with showers as scheduled for three of eight residents reviewed (Residents 2, 4, 5). Findings include: A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated November 29, 2019, indicated that the resident was cognitively intact and required extensive assistance from staff for bathing. Documentation in the resident's clinical record regarding bathing for January 1 through March 12, 2019, indicated that the resident was to receive showers during the day shift (7:00 a.m. to 3:00 p.m.) on Sundays and Wednesdays. However, there was no documented evidence that the resident received a shower as scheduled on Sundays, January 5, 12, 19 and 26, and February 2 and 23, 2020, and Wednesdays, January 1, 8, 15 and 22, and March 11, 2020. There was no documented evidence that showers were offered and refused by the resident. Interview with Resident 2 on March 13, 2020 at 2:09 p.m. revealed that she preferred to receive showers, and she did not know why they were not always provided. An admission MDS assessment for Resident 4, dated September 16, 2019, revealed that the resident was cognitively intact and dependent on staff for bathing. Documentation in the resident's clinical record regarding bathing for December 1, 2019, through March 12, 2020, revealed that the resident was to receive showers during the day shift on Tuesdays and Fridays. However, there was no documented evidence that the resident received a shower on Tuesdays, December 3, 10, 17, 24 and 31, 2019, and Fridays, December 13 and 27, 2019, and January 17 and 31, 2020. There was no documented evidence that the resident was offered and refused the showers. A quarterly MDS assessment for Resident 5, dated February 2, 2020, indicated that the resident was cognitively intact and dependent on staff for bathing. Documentation in the resident's clinical record regarding bathing for January 1 through March 12, 2020, revealed that the resident was to receive showers during the day shift on Tuesdays and Fridays. However, there was no documented evidence that the resident received a shower on Tuesday, February 25, 2020, and Fridays, January 3, 10, 17, 24 and 31, and February 7, 21 and 28, 2020. Interview with Resident 5 on March 13, 2020, at 2:00 p.m. revealed that she preferred showers and was told that because there was not enough staff, there was no time to give her scheduled showers. Interview with the Nursing Home Administrator on March 13, 2020, at 5:10 p.m. confirmed that there was no documented evidence why showers were not provided as scheduled for Residents 2, 4 and 5. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 clinical record reviews, and resident and staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide showers as scheduled for three of eight residents reviewed (Residents 2, 4, 5). Findings include: A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated November 29, 2019, indicated that the resident was cognitively intact and required extensive assistance from staff for bathing. Documentation in the resident's clinical record regarding bathing for January 1 through March 12, 2019, indicated that the resident was to receive showers during the day shift (7:00 a.m. to 3:00 p.m.) on Sundays and Wednesdays. However, there was no documented evidence that the resident received a shower as scheduled on Sundays, January 5, 12, 19 and 26, and February 2 and 23, 2020, and Wednesdays, January 1, 8, 15 and 22, and March 11, 2020. There was no documented evidence that showers were offered and refused by the resident. Interview with Resident 2 on March 13, 2020 at 2:09 p.m. revealed that she preferred to receive showers, and she did not know why they were not always provided. An admission MDS assessment for Resident 4, dated September 16, 2019, revealed that the resident was cognitively intact and dependent on staff for bathing. Documentation in the resident's clinical record regarding bathing for December 1, 2019, through March 12, 2020, revealed that the resident was to receive showers during the day shift on Tuesdays and Fridays. However, there was no documented evidence that the resident received a shower on Tuesdays, December 3, 10, 17, 24 and 31, 2019, and Fridays December 13 and 27, 2019, and January 17 and 31, 2020. There was no documented evidence that the resident was offered and refused the showers. A quarterly MDS assessment for Resident 5, dated February 2, 2020, indicated that the resident was cognitively intact and dependent on staff for bathing. Documentation in the resident's clinical record regarding bathing for January 1 through March 12, 2020, revealed that the resident was to receive showers during the day shift on Tuesdays and Fridays. However, there was no documented evidence that the resident received a shower on Tuesday, February 25, 2020, and Fridays, January 3, 10, 17, 24 and 31, and February 7, 21 and 28, 2020. Interview with Resident 5 on March 13, 2020, at 2:00 p.m. revealed that she preferred showers and was told that because there was not enough staff, there was no time to give her scheduled showers. Interviews with Nurse Aides 1 and 2 on March 13, 2020, at 2:20 p.m. and 2:25 p.m., respectively, revealed that on some days there was not enough staff to allow them to offer the residents showers as scheduled. They stated this was especially true when staff were pulled from one unit and sent to the other unit. Interview with the Nursing Home Administrator on March 13, 2020, at 5:10 p.m. confirmed that there was no documented evidence why showers were not provided as scheduled for Residents 2, 4 and 5. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, manufacturer's instructions and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from significant medication errors by failing to obtain blood pressure and pulse rates as ordered by the physician for one of eight residents reviewed (Resident 2), and by failing to provide an antibiotic as ordered for one of eight residents reviewed (Resident 3). Findings include: physician's orders [REDACTED]. 60 beats per minute. Resident 2's Medication Administration Record [REDACTED]. Interview with the Corporate Consultant on March 13, 2020, at 5:35 p.m. confirmed that there was no documented evidence that nursing staff obtained Resident 2's blood pressure and pulse readings prior to administering [MEDICATION NAME] on January 24 and 20, 2020. The facility's policy regarding medication administration, dated October 14, 2019, indicated that the nurse who provided the medication was to document his/her initials under the date and time specific for the dosage provided, and that documentation was to be done immediately after administration and/or refusal of the medication. physician's orders [REDACTED]. Resident 3's MAR for February 2020 indicated that IV [MEDICATION NAME] was to be provided daily at 6:00 a.m., 2:00 p.m. and 10:00 p.m. A medication and nursing note dated February 5, 2020, revealed that the 6:00

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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) a.m. dose of IV [MEDICATION NAME] was not provided and that the resident left the facility at 7:06 a.m. for a physician's appointment. There was no documentation regarding why the medication was not provided before the resident left the facility that a.m. The MAR indicated [REDACTED]. Interview with the Director of Nursing on March 13, 2020, at 7:08 p.m. revealed that medications can be administered one hour prior to their scheduled time and IV [MEDICATION NAME] should have been administered to Resident 3 during the a.m. of February 5, 2020, if there was time to do so before her appointment. She also confirmed that there was no documented evidence why the medication was not administered on February 6, 2020, at 2:00 p.m. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, it was determined that the facility failed to ensure that proper infection control practices were followed during medications administration one of eight residents reviewed (Resident 7), and failed to ensure proper hand hygiene was performed during incontinent care for one of eight residents reviewed (Resident 8). Findings include: Observations during medication administration on March 13, 2020, at 8:31 a.m. revealed that while preparing medications for Resident 7, Licensed Practical Nurse 3 dropped a 40 milligram (mg) tablet of [MEDICATION NAME] (medication that rids the body of excess fluid) onto the top of the medication cart. The nurse then used her bare fingers to pick the tablet up and place it in the plastic medication cup. She then administered the medications to Resident 7. Interview with Licensed Practical Nurse 3 on March 13, 2020, at 8:33 a.m. confirmed that she should have put on a glove and should not have touched Resident 7's medication with her bare fingers. Interview with the Director of Nursing on March 13, 2020, at 1:30 p.m. confirmed that Licensed Practical Nurse 3 should not have touched Resident 7's medication with her bare fingers. The facility's policy regarding cleaning the glucometer (device used to test the blood sugar level in a sample of blood), dated October 4, 2019, indicated that to clean and disinfect the glucometer, staff were to use a disinfectant provided by the facility. The glucometer was to be cleaned before and after each resident use. The facility's policy regarding hand washing/hand hygiene, dated October 4, 2019, indicated that hand washing should be done after contact with body fluids, even if the hands are not visibly soiled, and also after removing gloves. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated January 15, 2020, indicated that the resident was cognitively impaired, required extensive assistance for hygiene, and was always incontinent of urine and stool. Observations on March 13, 2020, at 4:15 p.m. revealed that Nurse Aides 1 and 4 provided incontinent care for Resident 8. With gloves on, Nurse Aide 1 removed the resident's wet pants and incontinent brief, cleaned the resident, and then with the same gloves on, she applied protective cream to the resident's skin and put a new incontinent brief on. Interview with Nurse Aide 1 on March 13, 2020, at 4:32 p.m. confirmed that she did not remove her gloves and wash her hands after providing incontinent care for Resident 8. Interview with the Director of Nursing on March 13, 2020, at 7:05 p.m. confirmed that Nurse Aide 1 should have removed her gloves and washed her hands after cleaning the resident and before providing any further care. 28 Pa. Code 211.12(d)(1)(5) Nursing services.