| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395328 | A. Building<br>B. Wing | 02/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brethren Village | 3001 Lititz Pike<br>Lancaster, PA 17606 |

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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765<br><br>Based on review of facility policy, clinical records, hospital records, and staff interviews, it was determined the facility failed to provide necessary services of consistent wound treatment and ensure correct wound medication was applied to an unstageable wound (obscured full-thickness skin and tissue loss). The failure caused actual harm to Resident CL1 when the wound deteriorated and become infected resulting in hospitalization and unnecessary pain for one of three residents reviewed. (Resident CL1)<br><br>Findings include:<br><br>Review of the facility's policy titled Freedom from Abuse, Neglect, and Exploitation last revised in [DATE], revealed, facility is committed to interacting with and treating its Residents with dignity and respect. While a resident at or in the care of the facility, each resident is to be free from Abuse, exploitation, fraud, misappropriation of property, harassment, neglect, and mistreatment. Neglect is defined as the failure of the facility, its Team Members, or service providers to provide care, goods, or services to a Resident necessary to avoid physical harm, pain, mental anguish, or emotional distress.<br><br>Review of Resident CL1's diagnosis list includes thoracic spinal cord injury, and Diabetes (group of metabolic disorders characterized by a high blood sugar level over a prolonged period).<br><br>Review of Resident CL1's Admission Braden Scale (scale used for predicting pressure sore risk) completed on [DATE], revealed resident was At Risk for developing pressure ulcers.<br><br>Review of Resident CL1's admission skin assessment revealed Resident CL1 was admitted to the facility on [DATE], with an improving Stage 3 Pressure Ulcer (full thickness skin loss) to the coccyx (commonly known as the tail bone is a small triangular bone located at the bottom of the spine) with a measurement of 1.2 x 1.0 x 0 cm (centimeter).<br><br>Review of Resident CL1's physician order dated [DATE], revealed a new wound treatment to cleanse the coccyx/sacrum with normal saline and apply Medihoney (dressing that aids and supports debridement and a moist wound healing environment in acute and chronic wounds and burns) and Calcium Alginate (wound dressing used to absorb wound exudate) then cover with dressing daily in the evening and as needed.<br><br>(continued on next page) |

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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident CL1's [DATE], Treatment Administration Record (TAR) and progress notes failed to reveal documented evidence of Resident CL1's unstageable coccyx wound was treated on [DATE], [DATE], and [DATE].<br><br>Interview conducted with Licensed Nursing Employee E4 on February 5, 2025, at 1:30 p.m., revealed the daily Medihoney wound treatment order expired on [DATE], and was not renewed by nursing. The as needed treatment order remained and was administered on [DATE]. Further interview with licensed nursing Employee E4 confirmed the daily wound treatment order should have been renewed on [DATE].<br><br>Review of Resident CL1's clinical record failed to reveal documentation of the attending physician being notified of the missed wound care treatments on [DATE], [DATE], and [DATE].<br><br>Review of Resident CL1's Wound and Skin Evaluation dated [DATE], at 7:22 a.m., revealed Resident CL1's coccyx wound was deeper with new slough (layer of dead, yellow or white tissue that covers the wound bed) areas distal to the opening. The wound was identified as unstageable pressure ulcer with measurement of 1. 0 x 4.3 x 2.5 cm. with 100% slough. A new treatment of Santyl (topical medication used for removing damaged or burned skin to allow for wound healing and growth of healthy skin) was recommended.<br><br>Review of Resident CL1 physician's order dated [DATE], revealed a wound care order to cleanse the coccyx/sacral wound with normal saline, apply a Santyl pack with Calcium Alginate then cover it with a foam dressing daily.<br><br>Interview with the Nursing Home Administrator (NHA) on February 5, 2025, at 1:00 p.m. revealed when the wound nurse assessed the resident's coccyx wound on [DATE], he/she discovered that the Santyl medication was not available but the Treatment Administration Record was documented as treatment was administered. Facility investigation revealed the Santyl medication was incorrectly entered in the computer which resulted in the medication not being delivered. The Santyl medication was re-ordered.<br><br>Interview with licensed nurse Employee E3 on February 5, 2025, at 2:00 p.m. revealed on [DATE], Resident CL1's Santyl medication was not available in the facility, the nurse stated the wound was instead cleansed with normal saline and was lightly packed with Calcium Alginate then covered with a foam dressing. Employee E3 reported the same treatment without the santyl was done on [DATE], and [DATE]; since the Santyl medication was still not available. Employee E3 reported she/he assumed the medication would be delivered soon and did not call the pharmacy to follow up on the medication, did not inform the supervisor that medication was not available, and did not inform the physician that the medication was not available and therefore treatment order was not done as ordered on [DATE], [DATE], and [DATE].<br><br>Review of Resident R1's nursing progress notes dated [DATE], at 2:00 p.m., revealed the wound dressing was replaced due to soilage, awaiting delivery of Santyl from the pharmacy, the order was re-entered in the computer.<br><br>Review of the pharmacy delivery records revealed Resident CL1's Santyl medication wasn't delivered to the facility until [DATE], four days after it was ordered by the physician.<br><br>(continued on next page) |

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| Brethren Village | 3001 Lititz Pike<br>Lancaster, PA 17606 |

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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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident CL1's Wound and Skin Evaluation, dated [DATE] 8:18 a.m., revealed Resident CL1's coccyx wound was determined unstageable with a measurement of 4.9 x 4.4 x 2.5 cm. with 4.0 cm tunneling (wound that progressed to form passageways underneath the surface of the skin) at 6 o'clock, 100% slough with increased moderate purulent (product of inflammation that contains pus (e.g., leukocytes, bacteria, and liquefied necrotic debris), and moderate odor. Further review of same document revealed a wound culture was ordered and collected due to purulent discharge and odor in the area and resident's body temperature of 102 F (farenheit) recorded the previous evening. Resident CL1's current temperature was 99.9 F (normal body temperature range for adults is 97.0 - 99.0 F).<br><br>Review of the wound culture report dated February 1, 2025, revealed Resident CL1's coccyx wound was positive for the following organisms: Staphylococcus Aureus, Enterococcus Avium, Enterococcus Faecalis, and Morganella Morganii.<br><br>Review of CL1's clinical records revealed Resident CL1's wound treatment was changed, antibiotic treatment was started, and Resident CL1 was scheduled to be seen by a wound specialist.<br><br>Review of the wound consult dated February 3, 2025, revealed the Patient (Resident CL1) with a Stage 4 Pressure Ulcer (Full-thickness skin and tissue loss) of sacrum, diffuse necrotic tissue (The death of the cells in the body tissue) in the base. Skin exam revealed Stage 4 sacral ulcer with necrotic tissue, foul odor, (+) rough exposed bone. The same report revealed that the physician attempted to do debridement (Removal of dead, infected, or damaged tissue from a wound), but the patient was sensate unable to accomplish much. The physician recommended operative debridement in the Operating Room and Intravenous (IV) (medication administered in vein) antibiotics.<br><br>Review of Resident CL1's clinical record revealed Resident CL1 was sent to the hospital on February 4, 2025.<br><br>Review of the hospital record document titled History and Physical, dated February 5, 2025, revealed patient (Resident CL1) was seen in the wound clinic by surgery [physician's name] and tried to debride the diffuse necrotic base, but the patient did not tolerate it due to pain. Admission was requested for debridement under general anesthesia. The resident was placed on IV antibiotics and was referred to surgery for wound debridement.<br><br>Review of information dated [DATE] submitted by the facility, on Janaury 29, 2025 revealed the faciltiy substantiated neglect for Employee E3 and Employee was reeducated.<br><br>The above information was conveyed to the Nursing Home Administrator and Director of Nursing on February 6, 2025, at 2:30 p.m.<br><br>The facility failed to provide wound treatment to Resident CL1's unstageable coccyx consistently and failed to ensure the correct wound treatment was administered. This failure resulted in actual harm to Resident CL1 causing the wound to deteriorate, become infected, leading to hospitalization where added surgical procedures added unnecessary pain.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee<br><br>Previously cited [DATE]<br><br>(continued on next page) |

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| Brethren Village | 3001 Lititz Pike<br>Lancaster, PA 17606 |

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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management<br><br>Previously cited [DATE]<br><br>28 Pa. Code 201.18(e)(3) Management<br><br>Previously cited [DATE]<br><br>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services<br><br>Previously cited [DATE] |

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|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>41765<br><br>Based on review of the Pennsylvania Professional Nursing Practice Act, facility policy and procedure review, clinical records review and staff interviews it was determined the facility failed to ensure that staff met the professional standards for a licensed nurse in following a physician's wound care order for one of three residents reviewed (Resident CL1).<br><br>Finding Include:<br><br>The Professional Code, Title 49, Professional and Vocational Standards (Pennsylvania Professional Nursing Practice Act), Chapter 21.145(a) states that the Licensed Practical Nurse (LPN) is prepared to function as a member of the health-care team by exercising sound nursing judgement based on preparation, knowledge, and experience in nursing competency. The LPN participates in the planning, implementation, and evaluation of nursing care, using focused assessment in settings where nursing takes place.<br><br>Chapter 21.145 (3) states, an LPN shall follow the written, established policies and procedures of the facility that are consistent with the Act.<br><br>A review of the facility's policy titled Skin Care/Integrity, last revised in February 2024, revealed that the facility's policy is to identify residents at risk for impairment in skin integrity, initiate appropriate preventative interventions, and provide treatment to promote healing, prevent infections, and prevent the development of pressure ulcers.<br><br>A review of the facility's policy titled Pressure Wounds, last reviewed in May 2024, revealed that wounds in the category of pressure will have an appropriate treatment to promote the healing process.<br><br>A review of the physician's order dated January 3, 2025, revealed a wound treatment to cleanse the coccyx/sacrum with normal saline and apply Medihoney (A dressing that aids and supports debridement and a moist wound healing environment in acute and chronic wounds and burns) and Calcium Alginate (A wound dressing used to absorb wound exudate) then cover with dressing daily in the evening and as needed.<br><br>A review of the January 2025, Treatment Administration Record (TAR) and progress notes revealed no documented evidence that Resident CL1's unstageable (Obscured full-thickness skin and tissue loss) coccyx (commonly known as the tail bone is a small triangular bone located at the bottom of the spine) wound was treated on January 20, 22, and 23, 2025.<br><br>Clinical records review failed to reveal that the physician was notified of the missed wound care treatment on January 20, 22, and 23, 2025.<br><br>A review of the physician's order dated January 23, 2025, revealed a wound care order to cleanse the Coccyx/sacral wound with normal saline apply a Santyl pack with Calcium Alginate then cover it with a foam dressing daily.<br><br>(continued on next page) |

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|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the pharmacy delivery records revealed that Resident CL1's Santyl medication was not delivered to the facility until January 27, 2025, four days after it was ordered by the physician.<br><br>An interview with licensed nurse Employee E3 was conducted on February 5, 2025, at 2:00 p.m. Employee E3 reported that on January 24, 2025, Resident CL1's Santyl medication was not available, the nurse reported that the wound was instead cleansed with normal saline and was lightly packed with a Calcium Alginate then covered with foam dressing. Employee E3 reported that the same treatment was done on January 24, and 25, 2025, since Santyl medication was still not available. Employee E3 reported that she/he assumed that the medication would be delivered soon. Employee E3 reported that she/he did not call the pharmacy to follow up on the medication, did not inform the supervisor that medication was not available, and did not inform the physician that the wound treatment order was not followed for three days.<br><br>The above was conveyed with the Nursing Home Administrator and Director of Nursing on February 5, 2025, at 2:00 p.m.<br><br>The facility failed to ensure that the staff met the professional standard on providing appropriate and ordered treatment to Resident CL1's coccyx wound.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee<br><br>Previously cited 4/6/23.<br><br>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management<br><br>Previously cited 4/6/23.<br><br>28 Pa. Code 201.18(e)(3) Management<br><br>Previously cited 4/6/23.<br><br>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services<br><br>Previously cited 4/6/23.<br><br>28 Pa. 211.10(c) Resident care policies |

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|---|---|
| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765<br><br>Based facility policy review, clinical record review, hospital record review, facility documentation review, and staff interviews, it was determined that the facility failed to provide consistent and appropriate treatment for an Unstageable Pressure Ulcer (obscured full-thickness skin and tissue loss), resulting in wound deterioration, infection, and hospitalization for one of three residents reviewed (Resident CL1).<br><br>Findings include.<br><br>Review of the facility's policy titled Skin Care/Integrity, last revised in February 2024, revealed that the facility's policy is to identify residents at risk for impairment in skin integrity, initiate appropriate preventative interventions, and provide treatment to promote healing, prevent infections, and prevent the development of pressure ulcers.<br><br>Review of the facility's policy titled Pressure Wounds, last reviewed in May 2024, revealed wounds in the category of pressure will have an appropriate treatment to promote the healing process.<br><br>Review of Resident CL1's diagnosis list includes thoracic spinal cord injury, neuromuscular dysfunction of bladder, and Diabetes (group of metabolic disorders characterized by a high blood sugar level over a prolonged period).<br><br>Review of Resident CL1's admission skin assessment revealed Resident CL1 was admitted to the facility on [DATE], with an improving Stage 3 Pressure Ulcer (Full thickness skin loss) measuring 1.2 x 1.0 cm to the coccyx (commonly known as the tail bone, is a small triangular bone located at the bottom of the spine). A wound treatment order was in place.<br><br>Review of Resident CL1's Admission Braden Scale (scale used for predicting pressure sore risk) completed on December 28, 2024, revealed resident was At Risk for developing pressure ulcers.<br><br>Review of Resident CL1's care plan revealed that the skin impairment care plan was developed on December 28, 2024, with interventions as follows: chair cushion; adequate nutrition; resident education; turning and positioning; incontinent care and to provide wound treatment as ordered.<br><br>Review of the physician's order dated January 3, 2025, revealed a wound treatment to cleanse the coccyx/sacrum with normal saline and apply Medihoney (dressing that aids and supports debridement and a moist wound healing environment in acute and chronic wounds and burns) and Calcium Alginate (wound dressing used to absorb wound exudate) then cover with dressing daily in the evening and as needed.<br><br>Review of the Wound and Skin Evaluation dated January 16, 2025, at 7:39 a.m., revealed Resident CL1's coccyx wound was unstageable with a measurement of 2.0 x 1.2 x 1.5 cm. with 80% slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed) with moderate serous drainage (watery, clear, or slightly yellow/tan/pink fluid that has separated from the blood and presents as drainage) with no signs of infection. Wound treatment remained Medihoney and Calcium Alginate.<br><br>(continued on next page) |

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|---|---|
| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident R1's January 2025, Treatment Administration Record (TAR) and progress notes failed to reveal documented evidence that Resident CL1's unstageable coccyx wound was treated on January 20, January 22, and January 23, 2025.<br><br>Review of Resident R1's clinical records failed to reveal the attending physician was notified of the missed wound care treatments on January 20, January 22, and January 23, 2025.<br><br>Interview conducted with Licensed Nursing Employee E4 on February 5, 2025, at 1:30 p.m., confirmed there were no documented evidence of the physcian being notified of the missed wound treatments.<br><br>Review of the Wound and Skin Evaluation dated January 23, 2025, at 7:22 a.m., revealed Resident CL1's coccyx wound was unstageable with a measurement of 1.0 x 4.3 x 2.5 with 100% slough and moderate serous drainage with no evidence of infection. The same note revealed deteriorating, the area was deeper with new slough areas distal to the opening. A new treatment of Santyl (topical medication used for removing damaged or burned skin to allow for wound healing and growth of healthy skin) was recommended.<br><br>Review of Resident R1's physician's order dated January 23, 2025, revealed a wound care order to cleanse the Coccyx/sacral wound with normal saline apply a Santyl pack with Calcium Alginate then cover it with a foam dressing daily.<br><br>Review of the pharmacy delivery records revealed that Resident CL1's Santyl medication was not delivered to the facility until January 27, 2025, four days after it was ordered by the physician.<br><br>Interview with licensed nurse Employee E3 was conducted on February 5, 2025, at 2:00 p.m. Employee E3 reported that on January 24, 2025, Resident CL1's Santyl medication was not available, the nurse stated the wound was instead cleansed with normal saline and was lightly packed with a Calcium Alginate then covered with foam dressing. Employee E3 reported the same treatment was done on January 25, and January 26, 2025, since Santyl medication was still not available. Employee E3 reported that she/he assumed the medication would be delivered soon. Employee E3 reported she/he did not call the pharmacy to follow up on the medication, did not inform the supervisor the medication was not available, and did not inform the physician the treatment order was not appropriately done.<br><br>Review of the Wound and Skin Evaluation, dated January 28, 2025, at 8:18 a.m., revealed Resident CL1's coccyx wound was unstageable with a measurement of 4.9 x 4.4 x 2.5 cm. with 4.0 cm tunneling (wound that progressed to form passageways underneath the surface of the skin) at 6 o'clock, 100% slough with increased moderate purulent (Is any product of inflammation that contains pus (e.g., leukocytes, bacteria, and liquefied necrotic debris), and moderate odor. Additional review of the same note revealed, a wound culture was ordered and collected due to purulent discharge and odor in the area and a temperature of 102 F the night before. The current temperature was 99.9 F (normal body temperature range for adults is 97.0 - 99. 0 F).<br><br>Review of the wound culture report dated February 1, 2025, revealed Resident CL1's coccyx wound was positive for the following organisms: Staphylococcus Aureus, Enterococcus Avium, Enterococcus Faecalis, and Morganella Morganii.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident CL1's clinical records revealed wound treatment was changed to continuous negative pressure wound vacuum at 125 mm Hg on January 29, 2025. The resident was placed on antibiotics and was scheduled for a wound clinic consult.<br><br>Review of the wound consult dated February 3, 2025, revealed the patient had a Stage 4 Pressure Ulcer (Full-thickness skin and tissue loss) of sacrum, diffuse necrotic tissue (death of the cells in the body tissue) in the base. Skin exam revealed Stage 4 sacral ulcer with necrotic tissue, foul odor, (+) rough exposed bone. The same report revealed that the physician attempted to do debridement (Removal of dead, infected, or damaged tissue from a wound), but the patient was sensate unable to accomplish much. Pre procedure wound area was 48.24 cm2 (square centimeter), post debridement measurements were 6.7 x 7.2 x 5.6 cm with 76-100% slough and 1-25% eschar. The physician recommended operative debridement in the Operating Room and Intravenous (IV) (medication administered in vein) antibiotics.<br><br>Review of Resident CL1's clinical records revealed Resident was sent to the hospital on February 4, 2025.<br><br>Review of the hospital record History and Physical, dated February 5, 2025, revealed patient was seen in the wound clinic by surgery [physician's name] and tried to debride the diffuse necrotic base, but the patient did not tolerate it due to pain. Admission (hospital) was requested for debridement under general anesthesia. The same note revealed that the diagnosis of admission was Pressure Injury of the sacral region, stage 4. The patient was placed on IV antibiotics and was referred to surgery for debridement.<br><br>The above information was discussed with the Nursing Home Administrator and the Director of Nursing on February 5, 2025, at 2:30 p.m.<br><br>The facility failed to ensure Resident CL1 was provided with consistent and appropriate wound treatment on her/his sacral wound which resulted in actual harm when the wound deteriorated and became infected causing hospitalization and a surgical procedure that led to unnecessary pain.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee<br><br>Previously cited 4/6/23<br><br>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management<br><br>Previously cited 4/6/23<br><br>28 Pa. Code 201.18(e)(3) Management<br><br>Previously cited 4/6/23<br><br>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services<br><br>Previously cited 4/6/23 |