| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 395569 | A. Building<br>B. Wing | 04/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Embassy of Hillsdale Park | 383 Mountain View Drive<br>Hillsdale, PA 15746 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for 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>31760<br><br>Based on review of facility policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse for one of 33 residents reviewed (Resident 58).<br><br>Findings include:<br><br>The facility's policy for abuse, dated March 14, 2024, indicated that the facility will not tolerate abuse, neglect, and exploitation of its residents or the misappropriation of resident property. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.<br><br>A significant change in status Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 117, dated June 8, 2023, revealed that the resident was usually understood, could usually understand, and had diagnoses that included dementia and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). A care plan for Resident 117, dated September 21, 2023, revealed that he exhibited behaviors of playing in his food, taking items, wandering (to move around or go to different places usually without having a particular purpose or direction), abusive language, sexually-inappropriate behaviors, and threatening behaviors. Interventions for Resident 117 indicated that if he is wandering in the hallway, attempt to keep him away from other residents, keep him out of reach of other residents when feasible, and when in the dining room for meals and activities attempt to keep the resident out of reach of other resident to prevent future incidents.<br><br>A significant change in status MDS assessment for Resident 58, dated August 29, 2023, revealed that the resident was understood, could understand, and had a diagnosis of Alzheimer's disease.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A nursing note for Resident 58, dated September 8, 2023, at 12:50 p.m. revealed that the nurse was called from the dining room by the care aides related to a resident-to-resident altercation. Resident 58 was in her room when Resident 117 was trying to enter. Resident 58 was then observed being kicked by Resident 117. The resident was then found on the floor in her bedroom. Resident 58 stated that Resident 117 was trying to enter her room and she told him that she did not want him in there. Resident 117 then kicked her causing her to fall over. The Registered Nurse Supervisor was called and notified of the incident. The resident's injuries were assessed by supervisor. The resident was assisted by staff back into her recliner at this time.<br><br>A nursing note for Resident 58, dated September 8, 2023, revealed that the licensed practical nurse on the floor notified the registered nurse that another resident kicked the resident and she fell to the floor. The nurse aide witnessed the other resident kicking this resident. When the registered nurse arrived on the floor the resident had gotten up and was in her room sitting in her chair. She stated that, he kicked her, and she fell . She denied having any contact with the resident prior to the incident. The resident stated that her right palm hurts. Upon assessment a bruise was noted on her right palm, which measured 3.5 centimeter (cm) by 1.8 cm. There were two bruises noted to her right elbow measuring 0.5 cm by 0.7 cm and 0.7 cm by 0.3 cm. A small abrasion was noted to her left elbow measuring 0.2 cm by 0.3 cm. A small bruise was noted to her right wrist area measuring 0.5 cm by 0.5 cm. The resident had an unmeasurable abrasion to her right buttock. The physician and psychologist were notified.<br><br>The facility report, dated September 8, 2023, indicated that an event occurred on September 8, 2023, at approximately 1:00 p.m. when Resident 117 was attempting to get into Resident 58's room. Resident 117 then kicked Resident 58 causing her to fall. Resident 58 was then assessed by the registered nurse and found to have a bruise on her right palm measuring 3.5 cm by 1.8 cm., two bruises on her right elbow measuring 0.5 cm by 0.7 cm and 0.7 cm by 0.3 cm, a small abrasion on her left elbow measuring 0.2 cm by 0.3 cm, a small bruise on her right wrist area measuring 0.5 cm by 0.5 cm, and an unmeasurable abrasion on her right buttock.<br><br>A statement completed by Nurse Aide 1, dated September 8, 2023, revealed that she was walking down the hall and saw Resident 117 halfway into Resident 58's room and then saw Resident 117 kick at Resident 58. Nurse Aide 1 ran into her room, and she was on the floor. Nurse Aide 1 then asked the residents what happened. Resident 58 said Resident 117 kicked her, and Resident 117 admitted kicking her.<br><br>Interview with the Nursing Home Administrator on April 10, 2024, at 10:24 a.m. confirmed that Resident 117 kicked Resident 58.<br><br>28 Pa. Code 201.14(a) Responsibility of Licensee.<br><br>28 Pa. Code 201.18(b)(1)(e)(1) Management.<br><br>28 Pa. Code 201.29(j) Resident Rights. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>19102<br><br>Based on review of facility policies and residents' clinical records, as well as staff interviews, it was determined that the facility failed to review and revise care plans for three of 33 residents reviewed (Residents 1, 3, 51).<br><br>Findings include:<br><br>The facility's policy regarding care plans, dated March 14, 2024, indicated that the care plan revisions would be reviewed, and revised as necessary, when a resident experiences a status change.<br><br>A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated January 19, 2024, indicated that the resident was moderately cognitively impaired and was not receiving an anticoagulant (blood thinner) medication. Resident 1's care plan, dated February 2, 2024, indicated that the resident had the potential for bleeding or hemorrhage related to the use of anti-coagulant medication.<br><br>A review of Resident 1's physician's orders and Medication Administration Record (MAR) for April 2024 revealed that the resident was not receiving an anticoagulant medication.<br><br>Resident 1's current care plan was not updated to indicate that the resident was not receiving an anti-coagulant medication.<br><br>Interview with the Nursing Home Administrator on April 10, 2024, at 1:28 p.m. confirmed that Resident 1's care plan was not updated to include the discontinuation of the anticoagulant medication.<br><br>An admission MDS assessment for Resident 3, dated March 29, 2024, indicated that the resident was cognitively intact, required assistance from staff for his daily care needs, and had diagnoses that included a wound infection of a Stage 3 pressure ulcer (a wound developed from constant pressure extend through the skin into deeper tissue and fat but does not reach muscle, tendon, or bone). A care plan for Resident 3, dated April 10, 2024, revealed that the resident was receiving Cefdinir and Ampicillin for a wound infection.<br><br>A review of Resident 3's physician's orders and MAR for March and April 2024 revealed that the resident received 300 mg of Cefdinir Oral Capsule daily and 500 mg of Ampicillin oral capsule every six hours from March 23, 2024, to March 30, 2024.<br><br>Resident 3's current care plan was not updated to indicate that the resident was no longer receiving the Cefdinir and Ampicillin.<br><br>Interview with the Nursing Home Administrator on April 10, 2024, at 9:57 a.m. confirmed that the care plan was not updated to indicate that Resident 3 was no longer receiving Cefdinir and Ampicillin and should have been.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An annual MDS assessment for Resident 51, dated February 1, 2024, revealed that the resident was cognitively intact, required assistance with care needs, and had diagnoses that included atrial fibrillation. A care plan for Resident 51, dated April 23, 2021, indicated that the resident had the potential for bleeding or hemorrhage related to the use of anti-coagulant medication.<br><br>Review of Resident 51's current physician's orders revealed that the resident was not receiving an anti-coagulant medication.<br><br>Interview with Regional Registered Nurse 2 on April 9, 2024, at 12:01 p.m. confirmed that Resident 51's care plan should have been revised when her anti-coagulant was discontinued in August 2023 and it was not.<br><br>28 Pa. Code 211.12(d)(5) Nursing Services. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>31760<br><br>Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders for blood sugar checks were obtained by a professional (registered) nurse for one of 33 residents reviewed (Resident 24).<br><br>Findings include:<br><br>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals.<br><br>Physician's orders for Resident 24, dated October 4, 2024, included an order for the resident to receive one 500 milligram (mg) tablet of Metformin (helps to control the amount of glucose (sugar) in your blood) in the morning at 7:00 a.m.<br><br>Resident 24's Medication Administration Record (MAR), dated March and April 2024, revealed that staff were obtaining the resident's blood sugar level prior to the administration of the 500 mg tablet of Metformin in the morning at 7:00 a.m. However, there was no documented evidence that an order was obtained from the resident's physician for staff to obtain the resident's blood sugar level prior to the administration of the Metformin.<br><br>Interview with the Nursing Home Administrator on April 11, 2024, at 11:30 a.m. confirmed that there was no documented evidence that an order was obtained from Resident 24's physician for staff to obtain the resident's blood sugar level prior to the administration of the Metformin, and that staff should have obtained an order.<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing Services. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>31760<br><br>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received care and treatment in accordance with professional standards of practice by failing to ensure that physician's orders were followed for four of 33 residents reviewed (Residents 12, 14, 22, 24).<br><br>Findings include:<br><br>The facility's policy regarding medication administration, dated March 14, 2024, indicated that staff were to obtain and record vital signs when applicable or per physician's orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.<br><br>An annual Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 12, dated February 22, 2024, revealed that the resident was understood and could understand others, was cognitively intact, and required minimal assistance with care.<br><br>A nursing note for Resident 12, dated March 16, 2024, revealed that the nurse aide noticed that the resident's left eye was red and swollen. The physician was notified and orders were received for polymyxin/trimethoprim ophthalmic solution (an eye drop used to treat eye infections) to be administered every three hours for seven days.<br><br>A review of Resident 12's Medication Administration Record (MAR) for March 2024 revealed that the eye drops were not available for administration for the first five doses. There was no documented evidence that the physician was made aware that the drops were unavailable or that the treatment would need to be extended to ensure the resident would receive the entire seven-day treatment as ordered.<br><br>Interview with the Nursing Home Administrator on April 10, 2024, at 10:27 a.m. confirmed that Resident 12 did not complete the entire treatment as ordered and the treatment should have been completed.<br><br>A quarterly MDS assessment for Resident 14, dated December 15, 2023, revealed that the resident was understood, could understand, and had diagnoses that included high blood pressure. A care plan for the resident, dated September 8, 2023, revealed that the resident was at risk for coronary artery disease (a condition that affects the heart). Staff were to administer medications for hypertension and document the response to the medication and any side effects. Staff were to monitor the blood pressure and notify the physician of any abnormal readings.<br><br>Physician's orders for Resident 14, dated September 2, 2023, included an order for the resident to receive one 2.5 milligram (mg) of Amlodipine (used to treat high blood pressure) one time a day for hypertension. Staff was to hold the medication for a blood pressure less than 90/60 millimeters of mercury (mm Hg) (a normal blood pressure for most adults is defined as a systolic pressure (top number) of less than 120 mm Hg and a diastolic pressure (bottom number) of less than 80 mm Hg).<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 14's Medication Administration Record (MAR), dated March and April 2024, revealed that there was no documented evidence that the resident's blood pressure was obtained prior to the administration of the 2.5 mg tablet of Amlodipine to determine if the medication should be withheld.<br><br>Interview with the Nursing Home Administrator on April 10, 2024, at 3:05 p.m. confirmed that there was no documented evidence that Resident 14's blood pressure was obtained prior to the administration of the Amlodipine to determine if the medication should be withheld.<br><br>A quarterly MDS assessment for Resident 22, dated December 12, 2023, revealed that the resident was understood, could understood others, was cognitively intact, independent for daily care needs, and received insulin (medication that lowers blood sugar levels).<br><br>Physician's orders for Resident 22, dated March 17, 2022, included an order for the resident to have her blood sugar checked four times a day and for the physician to be contacted if the blood sugar is less than 60 or greater than 350.<br><br>Resident 22's MAR, dated March, 2024 revealed that on March 3 at 9:00 p.m. the resident's blood sugar was 360 mg/dL; on March 10 at 11:45 a.m. it was 358; and on March 17 at 5:15 p.m. it was 376. There was no documented evidence that the physician was notified about the resident's blood sugar being above 350 mg/dL on these dates and times.<br><br>Interview with the Nursing Home Administrator on April 9, 2024, at 11:55 a.m. confirmed that there was no documented evidence that the physician was notified about Resident 22's elevated blood sugars as ordered.<br><br>A quarterly MDS assessment for Resident 24, dated January 10, 2024, revealed that the resident was understood, could understand, and had a diagnosis that included high blood pressure. A care plan for the resident, dated October 9, 2023, revealed that the resident was at risk for coronary artery disease. Staff were to administer medications for hypertension and document the response to the medication and any side effects. Staff were to monitor the blood pressure and notify the physician of any abnormal readings.<br><br>Physician's orders for Resident 24, dated January 16, 2024, included an order for the resident to receive one 0.1 mg tablet of Clonidine (used to treat high blood pressure) two times a day for hypertension at 7:00 a.m. and 7:00 p.m. Staff were to hold the medication for a blood pressure less than 90/60 mm Hg.<br><br>Resident 24's MARS, dated March and April 2024, revealed that there was no documented evidence that the resident's blood pressure was obtained prior to the 7:00 p.m. administration of the 0.1 mg tablet of Clonidine to determine if the medication should be withheld.<br><br>Interview with the Nursing Home Administrator on April 11, 2024, at 11:30 a.m. confirmed that there was no documented evidence that Resident 24's blood pressure was obtained prior to the administration of the Clonidine to determine if the medication should be withheld.<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>19102<br><br>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to follow recommendations from a wound consultation for two of 33 residents reviewed (Residents 3, 30).<br><br>Findings include:<br><br>The facility's policy regarding pressure ulcers, dated March 14, 2024, indicated that the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries.<br><br>An admission Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 3, dated March 29, 2024, indicated that she was cognitively intact, had no history of rejecting care, required extensive assistance from staff for daily care needs, and had an unhealed Stage 3 pressure ulcer.<br><br>A physician's progress note, dated March 29, 2024, revealed that Resident 3 was to be assessed for an air mattress to assist with pressure distribution.<br><br>Observations of Resident 3 on April 8, 2024, at 11:35 a.m. revealed that the resident did not have an air mattress. There was no documented evidence in the clinical record that Resident 3 had been assessed for an air mattress as requested by the physician.<br><br>Interview with the Nursing Home Administrator on April 10, 2024, at 9:33 a.m. confirmed that the resident did not have an air mattress, was never assessed for an air mattress, and that he should have been per the physician's request.<br><br>A quarterly MDS assessment for Resident 30, dated March 14, 2024, indicated that the resident was cognitively intact and had pressure ulcers (skin breakdown caused by pressure).<br><br>A wound clinic note, dated March 22, 2024, revealed that Resident 30 had a Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle) to the coccyx (lower part of spine) that measured 5.0 x 4.5 x 5.0 centimeters (cm) with undermining (tissue breakdown beneath the skin), and it was recommended that the wound be cleansed with 0.125 percent Dakins (used to prevent infection) solution and collagen (used to stimulate wound healing) and silver alginate (dressing used to prevent infection) be applied to the coccyx twice a day.<br><br>A wound clinic note, dated March 29, 2024, revealed that Resident 30 continued to have a Stage IV pressure ulcer to the coccyx, and it was recommended that the wound be cleansed with 0.125 percent Dakin's solution, and collagen and silver alginate be applied to the coccyx twice a day.<br><br>The Treatment Administration Record for Resident 30 for March 2024 revealed that the application of collagen and silver alginate to the resident's coccyx twice a day was not started until March 30, 2024.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | There was no documented evidence that the application of collagen and silver alginate to Resident 30's coccyx twice a day was started following the recommendations of the wound clinic on March 22, 2024.<br><br>Interview with the Nursing Home Administrator on April 10, 2024, at 9:34 a.m. confirmed that the treatments to Resident 30's coccyx were not completed as recommended by the wound clinic on March 22, 2024.<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31760<br><br>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the residents' environment remained free of accident hazards caused by residents with aggressive behaviors for four of 33 residents reviewed (Residents 44, 58, 61, 63).<br><br>Findings include:<br><br>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 14, dated December 15, 2023, revealed that she was understood, could understand, and had a diagnosis of dementia. A care plan for the resident, dated September 8, 2023, revealed that the resident had an alteration in behavior related to abusive attacks on staff and/or other residents; verbally abusive, threatening behaviors; argumentative with staff; yells at staff and other residents, and a history of resident-to-resident altercations. Staff were to intervene as needed to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation and take to another location as needed.<br><br>A nursing note for Resident 14, dated December 25, 2023, at 5:30 p.m. revealed that the resident was hollering at the residents in the dining room and singled one resident out, threatening to hit her with her hands clenched in fists. Residents were separated and Resident 14 was in her room at this time. A nursing note at 7:10 p.m. revealed that the resident went into Resident 58's room hollering at the resident. This licensed practical nurse went down the hall to see what was going on. Resident 14 was shaking Resident 58 and hit the resident in the stomach with a closed fist several times. The licensed practical nurse told the resident to stop, and she pushed Resident 58 and made the resident stumble out of her room. The licensed practical nurse told the resident that she cannot hit or push other residents and the resident insisted that this is her house and that Resident 58 was burning it down.<br><br>A nursing note for Resident 14, dated January 5, 2024, revealed that during breakfast another resident began speaking inappropriately to this resident, and she in turn, began verbally making comments that she would punch the other resident.<br><br>A nursing note for Resident 14, dated March 20, 2024, revealed that the writer was called to the unit at 8:30 p.m. by the licensed practical nurse reporting that the resident had slapped Resident 63's arm while in the hallway. The incident was witnessed by the hospitality aide who had reported it to the licensed practical nurse. The licensed practical nurse immediately separated the two residents. Upon entry to the unit both residents were away from one another and resting in their wheelchairs with staff nearby. Neither resident could give a description of what had occurred.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A significant change in status MDS assessment for Resident 117, dated June 8, 2023, revealed that the resident was usually understood, usually understands, and had diagnoses that included dementia and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). A care plan for the resident, dated September 21, 2023, revealed that the resident had exhibited behaviors of playing in his food, taking items, wandering (to move around or go to different places usually without having a particular purpose or direction), abusive language, sexually-inappropriate behaviors, and threatening behaviors. If the resident was wandering in the hallway, attempt to keep him away from other residents, keep the resident out of reach of other residents when feasible, and when in the dining room for meals and activities attempt to keep the resident out of reach of other resident to prevent future incidents.<br><br>A nursing note for Resident 44, dated July 16, 2023, revealed that the nurse aide hollered for the licensed practical nurse to come help her. The nurse aide stated, Resident 117 hit Resident 44 on the back. Resident 44 was standing in room [ROOM NUMBER] behind the nurse aide. The registered nurse was notified after Resident 117 was taken to his room.<br><br>A nursing note for Resident 117, dated September 8, 2023, at 1:22 p.m. revealed that the licensed practical nurse on the floor notified the registered nurse that this resident kicked Resident 58 in the leg and caused her to fall to the floor with minor injuries noted. Upon arrival to the unit the resident was in the hallway in his wheelchair. When asked what happened he refused to say anything. The licensed practical nurse stated that he told her he kicked Resident 58 after she kicked him. Resident 58 denied kicking him. The resident continues to self-propel in the hallway currently. A nursing note at 1:28 p.m. revealed that the licensed practical nurse notified the registered nurse that the resident punched Resident 44 in the buttocks as she walked away from him. Upon arrival, the resident was seen sitting in his room. The resident refused to explain what happened.<br><br>A statement Social Worker 3, dated September 8, 2023, revealed that he was completing MDS's in his office around 1:00 p.m. to 1:15 p.m. when a nurse aide called him into the hallway to help keep Resident 117 away from Resident 58. He brought Resident 117 to his office and spoke about what happened. Resident 117 said, I was going into her room, she told me to get out, she turned around and I kicked her in the butt. Resident 117 was in the office for about 15 to 20 minutes when the phone rang. Social Worker 3 answered and spoke on the phone and when he hung up, Resident 117 was no longer in his office.<br><br>A quarterly MDS assessment for Resident 58, dated February 29, 2024, revealed that the resident was understood, understands, and had a diagnosis of Alzheimer's disease. A care plan for the resident, dated February 23, 2023, revealed that the resident is/has a potential to be physically aggressive.<br><br>A nursing note for Resident 58, dated March 19, 2024, revealed that the licensed practical nurse notified the registered nurse at 6:30 p.m. that the resident had hit Resident 61 once in the back and another time in the left breast.<br><br>Following the above incidents, there was no documented evidence that the facility analyzed the key times, places, circumstances, and triggers that caused the multiple episodes of resident-to-resident altercations.<br><br>(continued on next page) |

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|---|---|---|---|
| | 395569 | A. Building<br>B. Wing | 04/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Embassy of Hillsdale Park | 383 Mountain View Drive<br>Hillsdale, PA 15746 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview with the Nursing Home Administrator on April 10, 2024, at 10:24 a.m. confirmed that Resident 117 had an altercation with Resident 58 and after the altercation then went and had an altercation with Resident 44. She indicated that Social Worker 3 should have gotten someone else to watch Resident 117 when he received the phone call.<br><br>28 Pa. Code 211.12(d)(5) Nursing Services. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>19102<br><br>Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to provide appropriate care to prevent urinary tract infections for one of 33 residents reviewed (Resident 1) who had an indwelling urinary catheter.<br><br>Findings include:<br><br>The facility's policy regarding indwelling urinary catheters (a flexible tube inserted and held in the bladder to drain urine), dated March 14, 2024, revealed that care would be taken to follow infection control guidelines when providing catheter care and emptying the drainage bag.<br><br>A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated January 19, 2024, revealed that the resident was moderately cognitively impaired, required assistance from staff for daily care activities, had an indwelling urinary catheter, and had diagnoses that included neurogenic bladder (lack of bladder control).<br><br>Physician's orders, dated December 28, 2023, included an order for the resident to have a urinary catheter, 18 French (size) with a 10 cubic centimeters (cc) balloon (located on the bladder end of the catheter and filled with sterile water to hold the tube in place).<br><br>Observations of Resident 1 on April 8, at 12:40 p.m. and April 10, 2024, at 8:18 a.m. revealed that the resident was in a wheelchair in his room and in the hallway, and his catheter tubing was in contact with the floor.<br><br>Interview with Registered Nurse 4 on April 10, 2024, at 8:21 a.m. confirmed that Resident 1's catheter tubing was on the floor and should not have been.<br><br>Interview with the Nursing Home Administrator on April 10, 2024, at 12:51 p.m. confirmed that Resident 1's catheter tubing should not have been in contact with the floor.<br><br>28 Pa. Code 211.12(d)(5) Nursing Services. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>48809<br><br>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that it was free from significant medication errors for one of 33 residents reviewed (Resident 22).<br><br>Findings include:<br><br>The facility's policy regarding medication administration, dated March 14, 2024, indicated that the facility was to administer medication in accordance with the physician orders.<br><br>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 22, dated March 14, 2024, revealed that the resident had diagnoses that included diabetes (a disease that interferes with blood sugar control) and received insulin.<br><br>Physician's orders for Resident 22, dated December 15, 2022, included an order for the resident to receive 6 units of Lispro insulin subcutaneously (injected just under the skin) one time a day in the morning, 6 units one time a day at the lunch meal, and 6 units one time a day at the supper meal, and to hold the insulin if the resident's blood sugar was less than or equal to 100 mg/dL.<br><br>Resident 22's Medication Administration Records for March and April 2024 revealed that on March 4, 2024, at 7:00 a.m. the resident's blood sugar was 93 mg/dL; on March 6, 2024, at 11:45 a.m. the resident's blood sugar was 98 mg/dL; on March 19, 2024, at 7:15 a.m. the resident's blood sugar was 88 mg/dL; on March 18, 2024, at 7:15 a.m. the resident's blood sugar was 80 mg/dL; and on April 1, 2024, at 11:45 a.m. the resident's blood sugar was 81 mg/dL.<br><br>There was no documented evidence that the resident's insulin was held on the above dates as ordered by the physician.<br><br>Interview with Regional Registered Nurse 2 on April 9, 2024, at 11:55 a.m. confirmed that Resident 22's insulin was not held when the resident's blood sugar was less than 100 mg/dL on the dates mentioned above and should have been held.<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing Services. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>43856<br><br>Based on review of policies and clinical records, medication manufacturer's instructions, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were properly labeled/dated for three of 33 residents reviewed (Residents 10, 11, 45).<br><br>Findings include:<br><br>The facility's policy for labeling medications, dated March 14, 2024, indicated that all pre-filled pens and multi-dose vials of medication maintained in the facility shall be labeled with date opened and the initials of the healthcare professional, and are to be discarded within 28 days unless otherwise specified by the manufacturer.<br><br>The most current manufacturer's instructions for insulin Humalog Kwikpen Pen-injector 100 unit/ml (milliliter) solution (a fast acting insulin) indicated that prefilled pens that are in use should be kept at room temperature and must be used within 28 days or be discarded.<br><br>Physician's orders for Resident 10, dated July 9, 2023, included an order for Keppra solution (medication used to treat seizures) 100 mg/mL 5 ml by mouth two times a day.<br><br>Physician's orders for Resident 11, dated March 20, 2023, included an order for Humalog KwikPen Pen-injector 100 unit/ml solution subcutaneously (directly under the skin) before meals and at bedtime per sliding scale.<br><br>Physician's orders for Resident 45, dated August 28, 2023, included an order for Humalog KwikPen Pen-injector 100 unit/ml solution subcutaneously (directly under the skin) before meals and at bedtime per sliding scale.<br><br>Observations on April 11, 2024, at 10:57 a.m. of the medication cart on the 200 unit revealed a multi-dose bottle of Keppra for Resident 10 that was in use and not dated when opened, and a Humalog KwikPen Solution Pen-injector for Resident 11 that was in use and not dated when it was opened.<br><br>Interview with Registered Nurse 4 at that time indicated that the multi-dose bottle of Keppra and insulin pen should have been dated when first opened.<br><br>Observations on April 9, 2024, at 8:59 a.m. of the medication cart on the ACU unit revealed that there was a Humalog KwikPen Solution Pen-injector for Resident 45 that was in use and it was not dated when it was opened. Interview with Licensed Practical Nurse 5 at that time indicated that the insulin pen should have been dated when first opened.<br><br>Interview with the Nursing Home Administrator April 11, 2024, at 10:55 a.m. confirmed that the medications should have been dated when opened.<br><br>28 Pa. Code 211.9(a) Pharmacy Services. |

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| F 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.<br><br>31760<br><br>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to obtain a physician's order for an invasive procedure to collect a specimen for a laboratory test for one of 33 residents reviewed (Resident 24).<br><br>Findings include:<br><br>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated January 10, 2024, revealed that the resident was understood and understands. Physician's orders, dated January 4, 2024, included an order to obtain a urine culture (a test that looks for and identifies bacteria in urine) and sensitivity (a test that helps find out which antibiotic will be most effective in treating a bacterial infection).<br><br>A progress note for Resident 24, dated January 5, 2024, revealed that the resident was straight cathed (an invasive procedure in which a plastic tube is inserted into the bladder) for a dark amber urine and the sample was sent to the lab.<br><br>There was no documented evidence that staff obtained a physician's order to obtain Resident 24's urine specimen via catheterization.<br><br>Interview with the Nursing Home Administrator on April 11, 2024, at 11:30 a.m. confirmed that there was no evidence that a physician's order was obtained for Resident 24 to be catheterized to obtain the urine specimen.<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>31760<br><br>Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies.<br><br>Findings include:<br><br>The facility's deficiencies and plan of correction for the State Survey and Certification (Department of Health) survey ending May 11, 2023, revealed that the facility developed plans of corrections that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending April 11, 2024, identified repeated deficiencies related to the revision of care plans, failure to ensure that residents remained free of significant medication errors, and medication storage and labeling.<br><br>The facility's plan of correction for a deficiency regarding revising care plans, cited during the survey ending May 11, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the QAPI committee was ineffective in correcting deficient practices related to revising care plans.<br><br>The facility's plan of correction for a deficiency regarding failure to ensure that residents remained free of significant medication errors, cited during the survey ending May 11, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F760, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding ensuring that residents remained free of significant medication errors.<br><br>The facility's plan of correction for a deficiency regarding proper storage and/or labeling of medications, cited during the survey ending May 11, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding storing and labeling residents properly.<br><br>Refer to F657, F760, F761.<br><br>28 Pa. Code 201.14(a) Responsibility of Licensee.<br><br>28 Pa. Code 201.18(e)(1) Management. |