| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 395403 | A. Building<br>B. Wing | 10/26/2021 |

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| Newport Meadows Health and Rehabilitation Center | 41 Newport Avenue<br>Christiana, PA 17509 |

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| F 0623<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>22502<br><br>Based upon clinical record review, it was determined the facility failed to notify the ombudsman's office of hospitalization s for six of six residents reviewed (Resident 22, Resident 32, Resident 39, Resident 86, Resident 100 and Resident 108).<br><br>Findings include:<br><br>Review of Resident 22's clinical record revealed that Resident 22 was admitted to the hospital on August 10, 2021, for pneumonia. Further review of Resident 22's clinical record failed to reveal evidence the ombudsman's office was notified of this hospitalization .<br><br>Review of Resident 32's clinical record revealed Resident 32 was admitted to the hospital on September 6, 2021 for a psychiatric admission. Further review of Resident 32's clinical record failed to reveal evidence the ombudsman's office was notified of this hospitalization .<br><br>Review of Resident 39's clinical record revealed Resident 39 was admitted to the hospital on October 21, 2021 for repair of a hip fracture. Further review of Resident 39's clinical record failed to reveal evidence the ombudsman's office was notified of this hospitalization .<br><br>Review of Resident 86's clinical records revealed resident was admitted to the hospital on September 7, 2021, for diagnosis of Sepsis (Infection in the blood stream). Further review of Resident 86's clinical record failed to reveal evidence the ombudsman's office was notified of this hospitalization .<br><br>Review of Resident 100's clinical records revealed resident was admitted to the hospital on August 29, 2021, for urinary tract infection. Further review of Resident 100's clinical record failed to reveal evidence the ombudsman's office was notified of this hospitalization<br><br>Review of Resident 108's clinical record revealed Resident 108 was admitted to the hospital in July 2021 for treatment of a urinary tract infection. Further review of Resident 108's clinical record failed to reveal evidence the ombudsman's office was notified of this hospitalization .<br><br>Interview with the Nursing Home Administrator on October 26, 2021, at 9:21 a.m. confirmed that the State ombudsman was not notified of the above transfers.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0623<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | 28 Pa. Code 201.14(a) Responsibility of Licensee<br><br>28 Pa. Code 201.18(e)(1) Management<br><br>Previously cited 1/31/20 |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>35913<br><br>Based on review of clinical records and facility provided documentation it was determined that the facility failed to timely identify a hip fracture after a fall, resulting in a delay of services causing continued pain to a resident and resulting in actual harm to one of six residents (Resident 39) and to timely assess a resident and notify attending physician of a fall for one of six residents reviewed (Resident 100).<br><br>Findings include:<br><br>Review of Resident 39's diagnosis list revealed diagnoses including dementia (irreversible, progressive degenerative disease of the brain resulting in loss of reality, contact and functioning ability), major depressive disorder (major loss of interest in pleasurable activities, characterized by change in sleep patterns, appetite and/or daily routine), and anxiety disorder (feelings of persistent anxiety).<br><br>Review of Resident 39's Quarterly Minimum Data Set (periodic assessment of resident needs) dated September 6, 2021 revealed Resident 39 required supervision of one staff person for ambulating in resident's room and in the hallway of the nursing unit.<br><br>Review of Resident 39's progress notes dated October 9, 2021 revealed Resident observed laying on her back on the floor near her bed with blanket around her feet. Staff report that resident had been sleeping in her bed prior to fall. Resident alert, has full passive ROM [range of motion] but slight limp noted on right leg once she was stood up by staff. [Physician] made aware and new order for xray right knee received.<br><br>Further review of Resident 39's progress notes dated October 9, 2021 revealed s/p [status post] fall, neuro checks WNLs [within normal limits], did not ambulate this shift, 2 assist to pivot, c/o [complained of] right leg pain, holding and rubbing right hip and keeps right knee bent. [mobile x-ray company] here and x-ray rt. Knee done at approx 1830. Tylenol given for pain with little effect.<br><br>Further review of Resident 39's progress notes dated October 9, 2021 revealed x-ray report to Rt knee is negative for fx. [fracture] No acute findings. Resident still showing signs of pain to Rt side. Will address with [physician] in the morning in regards to ordering a possible xray to Rt hip.<br><br>Review of Resident 39's progress notes dated October 10, 2021 at 6:31 a.m. revealed s/p unwitnessed fall, neuro checks continued this shift. VSS. No issues resident was awake throughout shift but stayed in bed.<br><br>Further review of Resident 39's progress notes dated October 10, 2021 at 2:39 p.m. revealed resident continues to express pain with movement to right leg. Tylenol given with minimal effect. Resident not ambulating this shift. [Physician] made aware and new order for xray right hip received.<br><br>Further review of Resident 39's progress notes dated October 10, 2021 at 8:40 p.m. revealed s/p fall, neuro checks WNLs, slept most of shift, will not ambulate, cont with s/s pain right leg. Total assist with ADLs.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident 39's progress notes dated October 11, 2021 at 4:46 a.m. revealed s/p unwitnessed fall on 10/09/2021, neuro checks WNL, grimacing and moaning with T&R [turning and repositioning] and ADL [activities of daily living] care, full, passive ROM to LLE, partial, passive ROM to RLE, non weight bearing, ice pack to right hip and Tylenol 650 mg at 0200 with + effect, in bed at this time in low position w/call bell in reach, drank approx. 240 ml [milliliters] fluids, awaiting mobile xray will cont. to monitor.<br><br>Further review of Resident 39's progress notes dated October 11, 2021 at 6:42 p.m. revealed x-ray result right hip show acute right femoral neck [top of femur at hip joint] fracture. [physician] made aware and requested resident sent to ER. Daughter informed and would like resident to go to [acute care facility] 911 contacted and resident transferred to hospital.<br><br>Review of Resident 39's x-ray report dated October 11, 2021 at 12:31 p.m. revealed acute femoral neck fracture is noted, nondisplaced with mild angulation.<br><br>Interview with Director of Nursing and Nursing Home Administrator on October 26, 2021 confirmed that Resident 39 had a fall on October 9, 2021. Interview further confirmed that Resident 39 continued to complain of pain to right leg, remained in bed and did not receive an x-ray of right hip until October 11, 2021 two days after the fall and one day after Resident 39's physician ordered the x-ray.<br><br>The facility failed to obtain an x-ray of Resident 39's right hip until two days after Resident 39's fall and one day after Resident 39's physician ordered the x-ray despite continued complaints of pain and lack of mobility causing actual harm to Resident 39.<br><br>Review of Resident 100's diagnosis list revealed syncope (fainting) and collapse, muscle weakness, COVID-19, and Atrial Fibrillation (irregular and rapid heartbeat).<br><br>Review of Resident 100's Minimum Data Set (MDS- assessment tool used to determine the management of care), dated March 2, 2021, revealed that the resident had severe cognitive impairment. The same MDS revealed that the resident was able to ambulate with the extensive assistance of one person.<br><br>Review of the nursing progress notes dated April 24, 2021, at 3:47 a.m., revealed that Resident 100 was administered Hydrocodone-Acetaminophen 5-325 mg for a complaint of right hip pain. The same note revealed that the resident was guarding his hip, moaning when rolled, and was not ambulating well.<br><br>Review of the nursing progress notes dated April 24, 2021, at 3:49 a.m., revealed the 3-11 shift staff reported that the resident was having trouble ambulating on 3-11 shift and had to have the care done in bed. The same note revealed that Resident 100 resisted care during the 3-11 shift, holding the right hip area, facial grimacing. As needed pain medication was administered.<br><br>Review of the nursing progress notes dated April 24, 2021, at 7:20 a.m., revealed that Resident 100 was evaluated due to a complaint of pain while being turned in bed. The resident complained of right hip pain, the right leg was observed shorter than the left. The resident was medicated for pain and was kept in bed with a pillow in between legs. The same note revealed, reported to the supervisor who is going to evaluate.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the nursing supervisor's progress notes dated April 24, 2021, at 1:50 p.m., revealed that on the night shift, Resident 100 had complained of right hip pain when rolled from side to side for incontinent care. The staff had the resident remain in bed due to complaints of pain with weight-bearing. The same note revealed that upon the nursing supervisor's examination, the resident had some shortening and some external rotation of the affected limb (right leg). The physician was notified and X-ray was ordered.<br><br>Review of the nursing progress notes dated April 24, 2021, at 6:40 p.m., revealed that Resident 100's right hip X-ray result was an Acute right intra-trochanter fracture (break on the thigh bone). The physician was notified and ordered to transfer Resident 100 to the hospital. The resident was admitted to the hospital for a right hip fracture.<br><br>Review of the facility documentation, including a statement of Nurse Assistant (NA), Employee E5 who worked on April 23, 2021, at 7-3 shift, revealed that Resident 100 was toileted but would not put his feet down.<br><br>Review of the facility documentation, including a statement of Nurse Assistant (NA), Employee E6, who worked on April 23, 2021, at 3-11 shift revealed that a report was given to him that the Resident 100 would not stand in the afternoon when being toileted. The statement revealed that during supper, the resident was heard saying ow, ow, ow, when asked if he was in pain, the resident just mumbled. No further signs of pain were observed. The statement further revealed that after supper, the resident was brought to the bathroom. Employee E6's statement revealed, I went to stand him up at the bar to sit him on the toilet like he usually does, he was not able to bear weight, so I sat him back down. Employee E6's statement revealed that the charge nurse was notified of the resident's pain.<br><br>Review of the progress notes dated April 23, 2021, at 7:32 p.m., revealed that Resident 100 was administered Hydrocodone-Acetaminophen 5-325 mg.<br><br>Review of Resident 100's clinical records failed to reveal that an assessment was conducted regarding resident 100's change in a condition identified on April 23, 2021, at the 3-11 shift. Clinical records reviewed also failed to reveal that the physician was notified of Resident 100's change in condition which included the inability to bear weight during toileting, and right hip pain during bed mobility until the afternoon of April 24, 2021.<br><br>The above informatin was conveyed to the Nursing Home Administrator on October 26, 2021, at 11:00 a.m.<br><br>The facility failed to timely assess and notify the physician of the change in condition related to right hip fracture.<br><br>483.25 Quality of Care<br><br>Previously cited 1/31/20, 9/1/20<br><br>28 Pa. Code 201.18(b)(1) Management<br><br>Previously cited 1/31/20, 9/1/20<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 28 Pa. Code 211.5(f) Clinical records<br><br>Previously cited 1/31/20, 9/1/20<br><br>28 Pa. Code 211.12(c) Nursing services<br><br>Previously cited 1/31/20, 9/1/20<br><br>28 Pa. 211.12(d)(1)(3)(5) Nursing services<br><br>Previously cited 1/31/20, 9/1/20 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>41765<br><br>Based on observation, review of medication manufacturer's guide and staff interview, it was determined that the facility failed to ensure medications were properly labeled and stored for two of seven medication carts (Chestnut 1, and Birch 2 Medication Cart), and one of three medication room (First Floor Chestnut Medication Room).<br><br>Findings include:<br><br>Review of the manufacturer's guidelines revealed Latanoprost eye drops must be used within 6 weeks after opening the bottle.<br><br>Review of manufacturer's guidelines revealed Dorzolamide eye drop (medication used in the treatment of glaucoma) should be discarded 28 days after first opening the bottle.<br><br>Review of the Azelastatine Ophthalmic (medication used to treat eye itchiness and redness) revealed to keep the eye drops only for four weeks once the bottle has been opened. Do not use the drops if the bottle has been open for longer than this. This helps to prevent the risk of eye infection.<br><br>Review of the Moxifloxacin Ophthalmic Solution (medication to treat eye infections) manufacturer's guidelines revealed not to use the medication after the expiration date. Discard 28 days after opening.<br><br>Review of manufactures' storage guidelines for Lantus Insulin Pen (long-acting insulin) revealed that the medication may be stored at room temperature and must be discarded within 28 days after opening.<br><br>An observation of the Chestnut 1 medication cart was conducted on October 21, 2021, at 9:10 a.m., in the presence of licensed nurse, Employee E8. During the observation, the following was observed:<br><br>*One bottle of Azelastatine Ophthalmic, used, and with no date opened.<br><br>*One bottle of Latanoprost ophthalmic, used, and with no date opened<br><br>*One Lantus pen was used and with no date opened.<br><br>An observation of the first-floor chestnut medication room was conducted on October 21, 2021, at 10:00 a.m. , in the presence of Employee E8. Interview with Employee E8 conducted at the time, revealed that the one refrigerator which had a lock was for medication storage, the other refrigerator (no lock) was for snacks and supplements. Observation of the snack/supplement refrigerator revealed two boxes of Avonex (medication to treat Multiple Sclerosis [slow progressive disease of the central nervous system]) and two boxes of Trulicity (medication used to treat diabetes). The refrigerator also contained snacks and milk supplements. Employee E8 reported that the medications were placed in the snack/supplement refrigerator because there was no more room in the medication refrigerator.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with Employee E8 on October 21, 2021, at 10:15 a.m., confirmed that insulin pen and eye drop medictiaons should have been dated once opened. Employee E8 also confirmed that the Avonex and Trulicity medications should have been stored in the medication refrigerator and not in the snack/supplement refrigerator.<br><br>An observation of the Birch 2 medication cart was conducted on October 21, 2021, at 11:10 a.m., in the presence of licensed nurse, Employee E9. The observation revealed the following:<br><br>*One bottle of Moxifloxacin ophthalmic, used, opened on September 15, 2021.<br><br>*One bottle of Dorzolamide ophthalmic was used, and with no date opened.<br><br>*One bottle of Latanoprost ophthalmic opened on August 26, 2021.<br><br>*One bottle of Latanoprost ophthalmic opened on September 1, 2021.<br><br>An interview with Employee E9 on October 21, 2021, at 11:15 a.m., confirmed that the eye drop bottle(s) should have been dated once opened and should not have been in the medication cart after the recommended use by date.<br><br>The above was conveyed to the Nursing Home Administrator on October 26, 2021, at 2:00 p.m.<br><br>The facility failed to properly store and label medications on the first floor Chestnut medication room, Chestnut 1, and Birch 2 medication cart.<br><br>28 Pa. Code 201.18(b)(1) Management<br><br>Previously cited 1/31/20, 9/1/20<br><br>28 Pa. Code 211.12(c) Nursing services<br><br>Previously cited 1/31/20, 9/1/20<br><br>28 Pa. 211.12(d)(1)(3)(5) Nursing services<br><br>Previously cited 1/31/20, 9/1/20 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>33840<br><br>Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to ensure that sanitation standards were maintained during dishwashing and the facility failed to ensure food was prepared in a sanitary manner in the kitchen.<br><br>Findings include:<br><br>Review of facility policy labeled, Ware Washing- Manual, date January 2021, revealed that (manually washed) dishware using the 3 step method of washing, rinsing, and sanitizing: the Food Service Director ensures all dietary staff are knowledgeable in how to properly test the chemical solution, and how and where to document that reading. The Food Service Director ensure that the sanitation solution reaches the PPM range designated by the manufacturer. Staff will also be responsible for logging this information before washing dishes for that meal.<br><br>Observations of the three-compartment sink on October 20, 2021 at 1:15 p.m. revealed sanitation test strips were not available to determine proper PPM compliance for the sanitation solution. Interview with Food Service Director Employee E3 at 1:15 p.m. revealed that the strips could not be located.<br><br>Facility documentation for low temperature dishwashing machine log found at the end of the three-compartment sink has not been completed for lunch and dinner since October 6, 2021. An interview with Food Service Director Employee E3 on October 20, 2021 at 1:20 p.m. revealed that log is to be filled out upon completion of the test strips and could not explain why the form was blank for the dates mentioned.<br><br>Further observations on October 20, 2021 at 1:20 p.m. revealed a thick batter like substance on the back splash and shelf of the oven. Brown, loose dirt also appeared on the floor next to the deep fryer.<br><br>The facility failed to ensure sanitation standards for dishwashing and failed to ensure that food was prepare in a sanitary manner.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee<br><br>28 Pa. Code 201.18(b)(1) Management |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Dispose of garbage and refuse properly.<br><br>33840<br><br>Based on observations and an interview with staff, it was determined that the facility did not ensure that garbage and refuse were disposed of properly.<br><br>Findings include:<br><br>During the initial tour of the dietary department on October 20, 2021, at 9:45 a.m. The receiving door for loading was in the dishwashing area. The door opened to three wheeled bins that were filled with trash. Two of the wheeled bins had three to four bags of trash in them. Observation of flies and insects landing on the bags of garbage was also made at this time. The third wheeled bin was overflowing with cardboard.<br><br>An interview conducted with Employee E3 at 9:50 a.m. revealed that the bins needed to be taken to the dumpster and should not be outside the receiving door.<br><br>A follow up observation conducted on October 20, 2021, at 1:20 p.m. revealed supplies being delivered. The receiving door was propped open. The garbage in the three bins from the earlier observation, remained outside the door. Insects were observed flying in and out of the kitchen area.<br><br>A third observation on October 25, 2021, at 8:56 a.m. revealed that the dumpsters were overflowing, and the lids were not closed. A squirrel was observed rummaging through the items sticking out of the dumpster.<br><br>An interview with Nursing Home Administrator on October 25, 2021, 10:15 a.m. confirmed that the trash should be properly placed in the dumpster.<br><br>The facility failed to maintain the outside dumpster/loading dock area in a safe and sanitary condition.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee<br><br>28 Pa. Code 201.18(b)(3) Management |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33840<br><br>Based on a review of clinical records and interviews with staff, it was determined that the facility failed to maintain complete and accurate medical records for two of 32 reviewed (Resident 70 and Resident 92).<br><br>Findings include:<br><br>Review of Resident 70's diagnosis list revealed Diabetes (failure of the body to produce insulin to enable sugar to pass from the bloodstream to cells for nourishment), and Anemia (lack sufficient healthy red blood cells to carry adequate oxygen to the body's tissues/organs).<br><br>Review of Resident 70's Minimum Data Set (MDS- assessment tool used to facilitate the management of care) dated June 30, 2021, revealed that the resident had severe cognitive impairment and required extensive two-person assistance with care.<br><br>Review of Resident 70's Braden Risk Assessment Scale (assessment tool used to determine risk factors for pressure ulcer development) dated July 2, 2021, revealed that the resident was at high risk for pressure ulcer development.<br><br>Review of Resident 70's progress notes dated July 7, 2021, at 12:16 p.m., revealed an existing unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough and eschar) left heel pressure ulcer. The same progress note revealed a newly identified right heel pressure ulcer with a measurement of 1. 0 x 0.8 cm (centimeter), 100 % eschar (dry scab, tan, brown or black in wound bed; dead tissue), a small amount of non-odorous serosanguinous (drainage that contains both blood and a clear yellow liquid known as blood serum), and a new wound treatment was ordered.<br><br>Review of the physician's wound progress note dated July 7, 2021, revealed that Resident 70's right lateral heel had an acute unstageable pressure ulcer, obscured full-thickness, and tissue loss. Initial wound encounter measurements were 1.0 cm length x 0.8 cm width with no measurable depth, with an area of 0.8 sq cm.<br><br>An interview with licensed nurse Employee E7 on October 26, 2021, at 10:00 a.m., revealed that skin checks are done weekly and documented.<br><br>Review of Resident 70's skin evaluation dated July 6, 2021, at 5:40 p.m., revealed No current skin issues noted at this time, no new skin issues noted.<br><br>Review of Resident 70's skin evaluation dated July 13, 2021, revealed No current skin issues noted at this time, no new skin issues noted.<br><br>An observation of Resident 70's right heel wound on October 25, 2021, at 11:00 a.m., in the presence of Employee E7 revealed that the wound was scabbed (hard crust cover on a healing wound). Employee E7 measured the wound and revealed 0.6 x 0.5 cm, treatment in progress.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395403 | A. Building<br>B. Wing | 10/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Newport Meadows Health and Rehabilitation Center | 41 Newport Avenue<br>Christiana, PA 17509 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview on October 26, 2021 at 10:00 a.m. with Employee E7, was conducted. Employee E7 was unable to provide an explanation as to why Resident 70's right heel pressure ulcer was identified at an unstageable stage. Employee E7 was also unable to provide an answer, why the July 13, 2021 skin evaluation, indicated Resident 70 did not have any current skin issues despite having a bilateral heel unstageable pressure ulcer present.<br><br>The above information was conveyed to the Nursing Home Administrator on October 26, 2021, at 2:00 p.m.<br><br>Review of Resident 92's clinical record revealed an admitted [DATE] with the diagnosis of adult failure to thrive (weight loss, decreased appetite, poor nutrition, and physical inactivity) and receiving hospice (end of life care) services.<br><br>Further review of Resident 92's clinical record revealed an admission weight taken on July 4, 2021 of 267.5 lbs.<br><br>Further review of the clinical record revealed on the Admission Comprehensive MDS (Minimum Data Set screening for care) Section K0200 Height and Weight the resident weight was recorded at 268 pounds.<br><br>Review of Resident 92's weights documented the next weight was taken September 1, 2021, of 134.7 lbs. Reweights confirmed this weight of 134.7 lbs, a 133 lb weight loss in two months. There is no further documentation regarding weight loss.<br><br>An interview conducted with the Nursing Home Administrator on October 22, 2021 at approximately 1:00 p. m. who could not explain the weight loss. Additionally, a progress note was submitted in the clinical record on October 22, 2021 3:35 p.m. by the dietician stating the resident was interviewed and has never weighed over 135 lbs. and the admission weight was incorrect.<br><br>28 Pa. Code 201.18(b)(1) Management<br><br>Previously cited 1/31/20, 9/1/20<br><br>28 Pa. Code 211.5(f) Clinical records<br><br>Previously cited 1/31/20, 9/1/20<br><br>28 Pa. Code 211.12(c) Nursing services<br><br>Previously cited 1/31/20, 9/1/20<br><br>28 Pa. 211.12(d)(1)(3)(5) Nursing services<br><br>Previously cited 1/31/20, 9/1/20 |