STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395223	A. BUILDING _____ B. WING _____	10/22/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER-WEST SHORE	770 POPLAR CHURCH ROAD CAMP HILL, PA 17011

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 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview and clinical record review, it was determined that the facility failed to provide reasonable accommodations of individual resident needs and preferences for one of 32 residents reviewed (Resident 2). Findings include: Review of Resident 2's physician's orders [REDACTED]. The loss of these motor neurons causes the muscles under their control to weaken and waste away, leading to paralysis and eventual death). Review of a, Quality Improvement Form (the facility's resident concern form, a form used by the residents to submit concerns or grievances to the facility management) submitted on behalf of Resident 2 on October 5, 2015, revealed the WIFI service in the facility was not operating necessary for communication and activity. Based on Resident 2's [DIAGNOSES REDACTED]. Resident 2 also uses the internet for communication with family members, friends, entertainment, etc. on a daily basis. An interview with Resident 2 on October 21, 2015 at approximately 11:00 a.m., revealed disappointment with not being able to use the internet for the time the service was out of order and that he was unable to communicate with family or use his communication device for pleasure. Further review of the, Quality Improvement Form revealed that Resident 2 was without WIFI resolution until October 16, 2015, as documented by facility staff. An interview with the Assistant Director of Nursing Services on October 21, 2015 at approximately 3:00 p.m., revealed that the cable company was on site and could not immediately identify a problem and eventually reported the problem was internal with the facility's Information Technology company. It was also confirmed that Resident 2 was without internet services until resolution. Review of the facility's, Grievance Form revealed that Resident 2 submitted a grievance to the facility on [DATE], stating he requested to be put to bed at 10:00 p.m., October 9, 2015, by Nursing Assistant 4 (NA 4). Review of witness statements submitted by the staff and attached to the, Grievance Form, revealed NA 4 was made aware of Resident 2's request to be put to bed but was found sitting at the nursing station and NA 4 stated, he wanted to go to bed at 10 p.m. but I don't have time for that. NA 4's statement revealed she clocked out for her break at 9:52 p.m. and returned at 10:22 p.m NA 4's statement also read Resident 2's evening care process would take up to 40 minutes. A, Witness Statement completed by NA 6 revealed that when she came to work at 11:00 p.m. on October 9, 2015, she saw Resident 2 sitting in his chair without his computer. She was informed by RN 2 that Resdient 2 had ask to go to bed at 10:00 p.m. NA 6 spoke to NA 4, in the lounge, and NA 4 confirmed that Resident 2 had ask to go to bed at 10:00 p.m., but that she didn't have time. There is no evidence in the clinical record indicating what time Resident 2 was put to bed on October 9, 2015. An interview with the Assistant Director of Nursing Services on October 22, 2015 at approximately 12:00 p.m., revealed an expectation that Resident 2 should have been provided the requested care. 28 Pa. Code 201.29(d) Resident rights. Previously cited 9/24/15, 4/16/15, 12/23/14. 28 Pa. Code 201.29(j) Resident rights. Previously cited 9/11/14, 10/10/13.
F 0322 **Level of harm** - Actual harm **Residents Affected** - Few	**Give proper treatment to residents with feeding tubes to prevent problems (such as aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers) and help restore eating skills, if possible.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview, and clinical record review, it was determined that the facility failed to provide nutrition to meet the resident's needs for one of 32 residents reviewed (Resident 2) and failed to provide evidence that a resident's insertion site was examined consistently to prevent or resolve possible skin irritation or local infection for one of 32 residents reviewed (Resident 19). Findings include: Review of Resident 2's physician's orders dated October 2015, revealed [DIAGNOSES REDACTED]. The loss of these motor neurons causes the muscles under their control to weaken and waste away, leading to paralysis and eventual death). Additional review of Resident 2's clinical record revealed a physician's order for Enteral Feeding (by means of a tube surgically placed in the stomach) four times per day, 1 can of [MEDICATION NAME] 1.5 (a calorie dense liquid food with a patented fiber blend that provides complete balanced nutrition) via the PEG tube (a percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach it allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus). Review of the Medication Administration Record [REDACTED]. An interview with Resident 2 on October 22, 2015, at approximately 10:15 a.m., who's BIMS (an assessment tool which provides a numerical number for mental status) was a 15 (no impairment), revealed he did not receive his 6:00 p.m. can of [MEDICATION NAME] via the PEG tube on October 21, 2015. Review of the Medication Administration Record [REDACTED]. The nursing progress note dated October 21, 2015, at 6:36 p.m., revealed that RN 3 went to give Resident 2 the prescribed [MEDICATION NAME] at 6:25 p.m., and Resident 2 was not in his room. She was informed by a nurse aide (name not given) that the resident had gone outside with a friend. There was no evidence that RN 3 made any additional attempts to provide Resident 2 with the physician ordered [MEDICATION NAME]. An interview with the Assistant Director of Nursing (ADON) on October 22, 2015, at approximately 2:00 p.m., revealed that on October 21, 2015, the 6:00 p.m., treatment administration of the [MEDICATION NAME] was not documented. Further interview with the ADON revealed an expectation that if Resident 2 was not in his room, he should have been located and given an option to receive his [MEDICATION NAME] feeding and that information would be expected to be documented in the Interdisciplinary Progress Notes. There is no evidence in the clinical record indicating that Resident 2 received his 6:00 p.m., [MEDICATION NAME] feeding on October 21, 2015. Review of the facility policy entitled, Golden Clinical Services for [DEVICE]S (PEG tubes), last revised 2013, revealed, the following individuals may have responsibility for gastrostomy tube ([DEVICE] (PEG tube)) replacement specific to state professional licensing requirements are the Nurse Practioner, the Physician's Assistant and the Physician. The recommendation is not to routinely replace the [DEVICE]s (PEG tubes). Reinsertion of the [DEVICE]s (PEG tubes) should only

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

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

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F 0322 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) be done if the tube is accidently removed or becomes dysfunctional, i.e., clogged or leaking. If the surgically-placed [DEVICE] (PEG tube) is in place then the Physician, Physician Assistant or Nurse Practioner may re-insert a replacement [DEVICE] (PEG tube) at their discretion. Licensed staff will not re-insert the [DEVICE] (PEG tube). This policy was the only guidelines provided by the facility related to [DEVICE]s. There were no other policies and procedures provided by the facility relating to the care of [DEVICE]s (PEG tubes). Review of the clinical record for Resident 19 revealed [DIAGNOSES REDACTED]. Resident 19 had the following conditions: [MEDICATION NAME] (artificial opening into the abdominal wall for urine drainage), [MEDICAL CONDITION] (artificial opening into the abdominal wall for small intestine drainage) and a PEG tube (Percutaneous Endoscopic Gastrostomy-flexible feeding tube placed through the abdominal wall and into the stomach for nutrition, fluids and/or medications to be administered, bypassing the mouth and esophagus, also called a [DEVICE]). Review of one of Resident 19's comprehensive MDS dated [DATE], revealed in the category, Nutritional Approach, that Resident 19 is marked as having a feeding tube. There was no evidence provided by the facility regarding when the PEG tube was inserted for Resident 19 or the age of the current PEG tube. Review of Resident 19's physician's orders dated June 24, 2015, revealed that the staff were to cleanse the ([DEVICE]) PEG tube with soap and water and pat dry every shift. Further review of Resident 19's Treatment Administration Record for October 2015, revealed that on October 7, 2015, on the day shift, there were no initials in the provided spaces to indicate that the PEG tube site was cleansed per the physician's order. Interview conducted on October 22, 2015, at 10:00 a.m., with NA 1 (a Nurse Aide) revealed that, she was assigned to Resident 19 and that on October 17, 2015, between 7:00 a.m. and 7:45 a.m., she gave a partial bed bath to the resident and that she did not wash around the resident's PEG tube site. As she was getting the resident ready for lunch around 10:30 a.m., she noticed a maggot roll down the resident's stomach. Resident 19 stated, Maybe this is why my stomach has been burning. An interview conducted on October 22, 2015, at 10:10 a.m., with LPN 6 revealed that she was called to Resident 19's room by NA 1. She lifted the gauze around the PEG tube site and saw crawling objects, tannish in color approximately 1 cm (centimeter) long, around the PEG tube site. LPN 6 revealed that the moving objects were crawling out of the PEG tube insertion site and that she removed more than 10 moving objects. An interview conducted on October 22, 2015, at 10:40 a.m., with RN 1 revealed that she was informed by LPN 6 of bugs on Resident 19. She got gloves, gauze, and saline Q-tips and went to Resident 19's room. She lifted the drainage gauze around the PEG tube and worm-like looking bugs were crawling all around the PEG tube and the surrounding tissue. They were gray, white in color and approximately a half inch long. She removed the bugs on the skin with the saline dampened gauze. She saw more bugs inside the PEG tube insertion site. When the site was sprayed with normal saline the worms came to the surface and were then wiped away. The ADON was at the facility and gave permission to send Resident 19 to the hospital. Review of a progress note dated October 17, 2015, at 11:28 a.m., written by RN 1 (a Registered Nurse) in Resident 19's clinical record revealed that on October 17, 2015, at 11:28 a.m., Resident is alert and oriented (person, place and time) x3. Able to make needs known. Incontinent of bowel and bladder. [MEDICATION NAME] (surgically opening to bladder to drain urine to collection bag) and [MEDICAL CONDITION] (surgical opening for the intestine to drain into a collection bag) drains intact. Double lumen central line (a devise inserted in a vein for the administering of fluids), dressing dry and intact. PEG tube flushed with no difficulties. Serosanguineous (bloody) drainage noted at PEG tube insertion site, redness noted surrounding site, possible infection noted upon assessment. Resident complaints of pain around PEG tube site rating 8 on 0-10 pain scale. Lung sounds clear to auscultation (listening), diminished in BLL (bilateral lower lobes). HR (heart rate) reg (regular). Abdomen soft, non-tender. Contractures (stiffening) of the extremities. Sacral (tail bone area) wound dressing intact. Vital signs stable; BP (blood pressure) 107/68 Pulse: 63 O2: 95% on room air Respirations: 18 even, non-labored Temp (temperature) 96.6 MD (Medical Doctor) notified, advised nursing staff to send resident to hospital. There is no evidence of an assessment of the PEG tube site in the resident's record until October 17, 2015, when there was a progress note written by RN 1. Review of information submitted to the Department of Health indicated that the facility noted that when the nurse aide was providing care to the resident on October 17, 2015, she noticed an object crawling in the PEG tube site. The resident was sent to the emergency room for evaluation on October 17, 2015, and returned to the facility the same day at approximately 6:30 p.m. Review of physician order dated October 17, 2015, at 11:15 a.m., revealed send to ER eval infected peg. The resident was transferred and admitted to the hospital on October 17, 2015, at 11:50 a.m., for evaluation of the PEG tube site. Review of a Progress note written by LPN 6 on October 17, 2015, at 6:38 p.m., revealed Resident 19 returned from the hospital at 6:30 p.m., all of the maggots were removed and a new peg tube was inserted. Review of the, Document Review Report from the hospital dated October 17, 2015, at 1:58 p.m., for Resident 19 revealed that the G tube DSG (dressing) and wound cleansed and found multiple, 'maggot looking' bugs coming out of wound area. Irrigated and collected aprox. ten in sterile (cup). Bugs are still alive. Additional review of the Document Review Report from the hospital indicated that the PEG tube was removed and a new one was inserted. The hospital report indicated that the PEG tube appeared old and neglected and should have been replaced a long time ago. The report also indicated that the surrounding superficial skin around the PEG tube indicated severe neglect of wound care and proper cleaning. During an interview conducted October 22, 2015, at 12:30 p.m., with the Nursing Home Administrator (NHA), the Director of Nursing and the ADON, it was revealed by the NHA that it is his expectation that LPN 6 and RN 1 would accurately and completely document the event with Resident 19 and the worms should not have been crawling out from Resident 19's PEG tube site. The facility failed to provide evidence that the resident's insertion site was examined consistently to prevent or resolve possible skin irritation or local infection causing the resident to require treatment at the hospital. 28 Pa. Code 201.18(b)(1) Management. Previously cited 9/3/15, 2/18/15, 12/23/14, 9/11/14, 7/23/14, 10/10/13. 28 Pa. Code 211.12(d)(1) Nursing services. Previously cited 9/24/15, 9/3/15, 4/16/15, 12/23/14, 9/11/14, 7/23/14, 1/22/14, 10/10/13. 28 Pa. Code 211.12(d)(3) Nursing services. Previously cited 9/3/15, 9/11/14, 7/23/14, 1/22/14, 10/10/13. 28 Pa. Code 211.12(d)(5) Nursing services. Previously cited 9/24/15, 9/3/15, 4/16/15, 2/18/15, 12/23/14, 9/11/14, 7/23/14, 1/22/14, 10/10/13.
F 0465 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** br>Based on observation, the resident group interview and staff interview, it was determined that the facility failed to provide a sanitary environment for one out of ten hallways observed (first floor hallway outside of the first floor dining room and therapy room). Findings include: Observations made on the following dates and times revealed a strong odor of urine in the first floor hallway outside of the first floor dining room and therapy room. October 20, 2015 at 9:40 a.m., 11:43 a.m., 12:38 p.m., 2:25 p.m. October 21, 2015 at 8:30 a.m., 12:50 p.m., 2:23 p.m., 2:39 p.m. October 22, 2015 at 10:49 a.m. On October 20, 2015 at approximately 1:45 p.m., during the resident group interview, one resident said that their family was, pissed that everyone had to smell the urine. It was observed that several of the other residents (11 in attendance at this time) nodded their heads in agreement. An interview with the Assistant Director of Nursing Services on October 21, 2015 at 2:15 p.m., revealed that the facilty is aware of the urine odor and that the smell lingers. 42 CFR 483.70(h) Safe/Functional/Sanitary/Comfortable Environment.

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F 0465 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Previously cited 9/11/14. 28 Pa. Code 207.2(a) Administrator's responsibility. Previously cited 2/18/15, 9/11/14.