STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395740	A. Building B. Wing	11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Chester Rehabilitation and Healthcare Center	800 West Miner Street West Chester, PA 19382

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41765 Based on facility's policy, clinical records, facility investigation reviews; and staff interviews, it was determined that the facility failed to provide supervision for a resident in the use of a non-approved heat compress resulting in harm of a second-degree burn (injury that involves the outer layer of the skin and part of the inner layer of the skin) for one of three residents reviewed (Resident CL1). This was identified as passed non-compliance. Findings include: Review of the facility's policy titled Heat: Application Of, with a revision date of June 1, 2021, revealed that a warm compress is the recommended method of applying moist heat and may be used as a nursing intervention or as ordered by a physician/advanced practice provider. Patients may not use heating pads. Nursing may not use hydrocollator packs (type of clay packs applied externally to alleviate inflammatory pain, joint pain, congestion, and strains) or microwavable hot packs. If a hydrocollator pack is needed, consult with rehabilitation staff. Review of Resident CL1's diagnosis list revealed Compression thoracic fracture (a bone in the spine collapses), Dorsalgia (pain in the upper back), and Rheumatoid Arthritis (chronic inflammatory disorder affecting many joints, including those in the hands and feet). Review of Resident CL1's Minimum Data Set (MDS- An assessment tool used to facilitate the management of care) dated October 1, 2021, revealed that the resident was cognitively intact and required supervision with no setup from staff for ambulation, transferring, personal hygiene, and grooming. Review of the nursing progress note dated November 14, 2021, at 12:56 p.m., revealed the charge nurse was requested by the family. Upon entering the room, the resident was sitting on side of the bed with a heating pad laying on the mattress. The resident's mid-back was observed with a 'burn-like' area. The resident reported that the heat pad was used for her/his back pain. The resident and the family were educated on the facility's policy regarding the use of heat pads. The burn area was assessed, and the physician was notified. Review of the Wound Evaluation report completed on November 14, 2021, revealed the second-degree burn to the spine had a measurement of 9.04 x 2.8 cm (centimeters) with a total area of 20.14 cm. The wound was treated with Silvadene cream (an anti-microbial medication used to treat and prevent wound infection in patients with burns). (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the physician's progress notes dated November 15, 2021, revealed that the resident was seen for chronic medical conditions and reported burn on the back. The physician progress notes indicated that Resident CL1 stated: was using a microwaveable heating pad, but it was not too hot and was wearing a polyester nightgown and the nightgown got too hot and caused a burn on my back. As per the note, the resident reported that she/he fell asleep on the heating pad, denied using a towel between the heating pad and her/his back. The resident was educated regarding the type of heating pad not permitted in the facility, resident verbalized understanding and informed the physician her/his daughter took it home. The same note revealed that the resident denied pain at the site, observed with a reddened area on the mid-back, worse over spine area, with no drainage noted. Review of the facility documentation including, Nursing Assistant (NA) Employee E3 statement completed on November 15, 2021, revealed that on November 14, 2021, Resident CL1 asked the NA to put the gel heat pad in the microwave, not more than 50 seconds, Employee E3 set the microwave for 30 seconds but had to answer a call light from another resident. On the way back to the room, licensed nurse Employee E4 informed Employee E3 that the heat pad was already given to Resident CL1. Interview with licensed nurse, Employee E4 on November 30, 2021, at 10:30 a.m., revealed that approximately 8:30 a.m., while doing medication pass, observed Resident CL1's light being answered by N. A, Employee E3. Upon entering resident CL1's room, the resident was asking for her/his heating pad that was taken by the N.A. The resident informed Employee E4 that the heating pad is the only thing that helps her/his back pain. Employee E4 informed the resident that her/his medication was ready, but the resident insisted on getting the heat pad as well. Employee E4 reported that she saw the resident's heating pad in the pantry and gave it to the resident, the nurse reported that the heating pad was not hot when she/he gave it to the resident. Employee E4 reported that the resident was alert and oriented and independent and often refused any assistance from the staff. Employee E4 confirmed that there was no physician order for the heat pack, as according to Employee E4, he/she wanted to provide a non-pharmacological intervention for the resident's back pain but was not aware that a microwavable beaded heating pad was not allowed to be used. Additionally during the interview, Employee E4 indicated, approximately lunchtime, the resident's son asked Employee E4 to assess the resident's back. Employee E4 reported that she observed a burn-like area on the resident's mid-back. The nurse reported that the area looked new. The resident's family refused to believe that the reddened area was a burn since they also use the same product and had never resulted in a burn. Employee E4 educated the family regarding the elderly's fragile skin but refused to listen and demanded to talk to the charge nurse instead. Interview on November 30, 2021 at 11:00 a.m. with the charge nurse, Employee E5 revealed on November 14, 2021, approximately 12 p.m., Resident CL1's son requested to talk to her/him. Employee E5 reported that the heating pad was observed on the bed, beside the resident. The nurse observed the resident's back and confirmed that it was a burn. Physician was made aware of burn, and a treatment was ordered. The heating pad was removed from the resident's room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with Employee E3 on November 30, 2021, at 11:15 a.m., revealed that the heating gel pad was provided by the family. Employee E3 indicated that on November 14, 2021, approximately 8:30 a.m., Resident CL1 asked nurse aide to microwave the heating pad for no more than 50 seconds. According to the N.A., after reading the instructions (heat for 40 seconds), she/he set up the microwave for only 30 seconds but left to answer another resident's call bell request for assistance. On the way back to the room, Employee E4 informed her/him that Resident CL1 had been waiting for the heating pad so she/he gave to the resident. Employee E3 reported that she/he was not sure if the heating pad was on the resident's plan of care. Review of Resident CL1's active care plan for pain revealed, a heating pad was not included as an intervention for managing the resident's back pain. Review of Resident CL1's Physician Order Sheet failed to reveal an order for a heating pad for pain management. The above information was conveyed to the Nursing Home Administrator on November 30, 2021, at 2:15 p.m. Interview with Assistant Director of Nursing on November 30, 2021 revealed the facility has been conducting audits, weekly to ensure that residents do not have heating pads/microwavable pads in the rooms. Interviews conducted on November 30, 2021 with Employees E3, E4, E5, E6, E8 and E9 revealed the facility has provided education regarding the use of heating pads within the facility and appropriate type and usage for residents. Staff were able to verbalize knowledge of and understanding of process when families bring heating pads/applicators into the facility. Staff indicated awareness of policy and prohibition of microwavable heating pads. The facility failed to provide supervision regarding the use of a non-approved heating pad for Resident CL1 which resulted in actual harm of a second-degree burn to the mid back. This deficiency is cited as past non-compliance. The facility implemented a corrective action plan which included: Immediate removal of the heating pad from the resident; Microwave was removed; Initial audit in all residents' rooms to determine that no other residents had a heating pad in their room; Staff education/re-in-service regarding heating pads/application of heat policy; and Random weekly audits for three months to ensure no heating pads are being used. A review of the facility documentation and staff interviews showed that the corrective action had been fully implemented and completed by November 29, 2021. 28 Pa. Code 201.18 (b)(1)(e)(1) Management Previously cited 5/6/21, 2/8/21, 8/31/20, 6/5/20 28 Pa. Code 211.5(h)Clinical records (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Previously cited 5/6/21,2/8/21, 8/31/20, 6/5/20 28 Pa. Code 211.12(d)(5) Nursing Services Previously cited 5/6/21, 8/12/21, 10/4/21, 2/8/21, 8/31/20, 6/5/20, 1/29/20 28 Pa. Code 211.12(d)(1)(3) Nursing Services Previously cited 5/6/21, 2/8/21, 8/31/20, 6/5/20 28 Pa. Code 211.12(c) Nursing Services Previously cited 1/29/20