STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395001	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Passavant Retirement and Healt	105 Burgess Drive Zelienople, PA 16063

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on review of facility policy, observation, and staff interview it was determined that the facility failed to maintain the confidentiality of resident's medical information on one of six nursing households (second floor Tionesta household). Findings include: Review of the facility policy Use of Laptops or other portable computers, last reviewed on 1/23/24, indicated that resident information should be kept confidential. The computer screen should be turned so that only the resident or resident's family can see the screen. Keep the lid partially closed if resident data is displayed and information is not actively being documented. No resident data should be displayed if information is not actively being documented. Review of facility policy Medication Administration-General Guidelines, last reviewed on 1/23/24, indicate privacy is always maintained for all resident information by closing computer screen when not in use. During an observation on 3/26/24, at 11:58 a.m., the medication cart/portable computer unit outside of room [ROOM NUMBER] Tionesta household was left unattended with the computer screen open with identifiable information so any passerby could see resident personal and confidential information. During an observation on 3/26/24, at 12:10 p.m., the medication cart/portable computer unit outside of room [ROOM NUMBER] Tionesta household was left unattended with the computer screen open with identifiable information so any passerby could see resident personal and confidential information. During an interview on 3/26/24, at 12:17 p.m., Licensed Practical Nurse Employee E7 confirmed the computer screen was open and that the facility failed to maintain resident identifiable personal and medical information in a confidential manner on one of six nursing households (second floor Tionesta household). 28 Pa. code: 211.5(b) Clinical records. 28 Pa. Code: 201.29(i) Resident Rights 28 Pa. Code: 211.12(d)(3) Nursing Services

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policies, clinical records, facility documents and staff interview, it was determined that the facility failed to ensure that residents received neurological assessment after an incident involving a fall for two of five residents (Resident R9 and Resident R69). Findings include: Review of facility policy Falls - Resident Treatment Of dated 1/23/24, indicated a fall will refer to an incident when a resident drops to the floor suddenly or if a resident moves from one plane to another. Incidents that are considered a fall are when a resident is slowly and gently lowered to the floor, or when a resident slowly and purposefully lies or sits on the floor. If the resident is on the floor and the incident was unobserved, staff is to presume that it was a fall and proceed accordingly. When there is doubt, an incident should be considered a fall. Review of facility policy Neurological Assessment - Using the Flowsheet dated 1/23/24, indicated that a Neurological Review Flowsheet will be initiated in the electronic medical record (EMR) or as a paper form and completed for all residents who have sustained head trauma, either from a fall or an act in which the resident is struck on the head. This EMR electronic assessment form or paper form will be completed every 15 minutes for one hour, every two hours for the next six hours, then every shift for 48 hours. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/26/24, indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and history of falling. Review of Resident R9's clinical records dated 9/19/23, indicated he had a fall on 9/19/23, after sliding out of a mechanical lift in the shower and being lowered to the floor by a staff member. The clinical records indicate that Resident R9 sustained two lacerations (a jagged or torn wound to the skin) to the right side of his head, a laceration to the right side of his neck, and an abrasion (a superficial wearing of the skin) to his right shoulder. Neurological checks were initiated. Review of Resident R9's Neurological Review Flow Sheet dated 9/19/23 and 9/20/23, indicated only nine neurological checks were completed out of 15 opportunities. During an interview on 3/27/24, at 10:05 a.m., Director of Nursing 1 (DON1) stated, Some of the neurological checks may have been completed on paper, we do hybrid charting. During an interview on 3/27/24, at 10:08 a.m., DON1 was unable to locate any additional neurological checks in Resident R9's clinical record. During an interview on 3/27/24, at 11:23 a.m., DON1 confirmed that Resident R9's neurological checks were not completed per facility policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record indicated Resident R69 was admitted to the facility on [DATE]. Review of Resident R69's MDS dated [DATE], indicated diagnoses of high blood pressure, Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), and Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of Resident R69's clinical records dated 2/6/24, indicated Resident R69 was observed with an abrasion on her forehead and an abrasion on her nose. Resident R69 was unable to clearly state what caused the abrasions due to a language barrier. Neurological checks were initiated due to a presumed fall. Review of Resident R69's Neurological Review Flow Sheet dated 2/6/24, and 2/7/24, indicated only 11 neurological checks were completed out of 15 opportunities. During an interview on 3/28/24, at 9:49 a.m., Licensed Practical Nurse (LPN) Employee E5 confirmed she was unable to locate additional neurological checks in Resident R69's clinical record. During an interview on 3/28/24, at 9:50 a.m., LPN Employee E5 confirmed that the facility failed to ensure that neurological assessments were completed for Resident R69 as required per facility policy. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management. 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 211.10(d) Resident care policies.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on facility policy, clinical record review, and interview, the facility failed to have a physician's order, and a care plan, for the use of an indwelling catheter (a tube placed in the bladder to drain urine), for one of four residents (Resident R193), and failed to ensure that appropriate treatment and services were provided for two of four residents (Resident R67 and R73) with an indwelling urinary catheter. Findings include: Review of facility policy Catheter Care; Urinary dated 1/23/24, indicated to review the resident's care plan to assess for any special needs of the resident. It is suggested to change catheters and drainage bags based on clinical indications, and a physician's order.Review of the Centers for Disease Control guidance Guidelines for Prevention of Catheter-Associated Urinary Tract Infections updated 6/6/19, indicated to keep the collecting bag below the level of the bladder at all times. Review of the clinical record indicated Resident R67 was admitted to the facility on [DATE]. Review of Resident R67's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/13/24, indicated diagnoses of high blood pressure, Benign Prostatic Hyperplasia (BPH - age-associated prostate gland enlargement that can cause urination difficulty), and obstructive uropathy (a condition in which flow of urine is blocked). Review of a physician order dated 3/17/24, indicated to change Resident R67's suprapubic (enters the body through an incision in the abdomen) catheter on the first day of every month, 18 French catheter size. During an observation on 3/25/24, at 9:56 a.m., Resident R67 was in bed with his urinary drainage bag uncovered and laying on his bed. During an interview on 3/25/24, at 10:26 a.m., Licensed Practical Nurse (LPN) Employee E1 confirmed that Resident R67's privacy cover was not being utilized for his urinary drainage bag. Review of the clinical record indicated Resident R73 was admitted to the facility on [DATE]. Review of Resident R73's MDS dated [DATE], indicated diagnoses of high blood pressure, obstructive uropathy, and retention of urine. During an observation on 3/25/24, at 10:16 a.m., Resident R73 was in bed with his urinary drainage bag uncovered and attached to the bed frame at head of the bed above the level of the bladder. During an interview on 3/25/24, at 10:26 a.m., LPN Employee E1 confirmed Resident R73's privacy cover was not being utilized and that his urinary drainage bag was above the level of the bladder. Review of a physician's order dated 10/7/22, indicated continuous suprapubic catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician's order dated 10/7/22, indicated once every month, change the catheter drainage bag. The bag/tubing is to be dated and initialed. During an interview on 3/28/24, at 11:42 a.m. Director of Nursing 1 (DON 1) confirmed that the physician order failed to indicate a catheter size for Resident R73. Review of the admission record indicated Resident R193 was admitted to the facility on [DATE], with the diagnoses of brain cancer (a cancerous mass or growth of abnormal cells in the brain), anxiety disorder, and neuromuscular bladder dysfunction (the name given to a number of urinary conditions in people who lack bladder control due to a brain, spinal cord, or nerve problem). Review of progress note dated 3/22/24, at 1:52 p.m., indicated hospice nurse here today. Foley catheter changed and hematuria (blood in the urine) was noted in the tubing at lunch. Review of Resident R193's physician orders on 3/28/24, at 11:20 a.m., failed to include an order for use of the indwelling urinary catheter. Review of Resident R193's care plan on 3/28/24, at 11:21 a.m., failed to include a care plan for use of the indwelling urinary catheter. Observation of Resident R193 on 3/28/24, at 11:28 a.m., indicated resident lying in bed with a foley catheter connected to a drainage bag. Interview on 3/28/24, at 11:29 a.m., Registered Nurse (RN) Employee E6 confirmed the foley catheter was in use. Interview on 3/28/24, at 11:40 a.m., DON 2 confirmed that the facility failed to have a physician's order, and a care plan, for the use of an indwelling catheter, for one of four residents (Resident R193).During an interview on 3/28/24, at 11:42 a.m. DON 1 confirmed that the facility failed to ensure that appropriate treatment and services were provided for two of four residents (Resident R67 and R73) with an indwelling urinary catheter. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.11(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on facility policy review, resident observations and interviews, clinical record review and staff interviews, it was determined that the facility failed to make certain a physician order for use of and cleaning of a Bi-PAP/CPAP machine (machines used to make breathing easier) and failed to develop a plan of care for one of three residents (Resident R58). Findings include: Review of the policy Respiratory Care Documentation dated 1/23/24, indicated nurses will be responsible for completing the eTAR (electronic treatment administration record), for any resident who has physician orders CPAP, Bi-PAP therapy. Review of the policy Respiratory Care Equipment Changes dated 12/12/23, indicated CPAP/BIPAP maintenance included the following: mask cleaning, headgear (helps secure the mask around the nose, mouth, or both to prevent pressure leaks during sleep) cleaning, tubing cleaning, humidifier chamber cleaning, filter cleaning, and replacement of worn-out components. Review of the admission record indicated Resident R58 admitted to the facility on [DATE]. Review of Resident R58's Minimum Data Set (MDS- a periodic assessment of care needs) dated 3/12/24, indicated the diagnoses of obstructive sleep apnea (OSA -intermittent airflow blockage during sleep), diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and high blood pressure. Review of Resident R58's physician orders on 3/28/24, at 9:00 a.m., failed to include an order for BiPAP/CPAP therapy. Review of Resident R58's care plan on 3/28/24, at 9:01 a.m., failed to include a plan of care for the use of BiPAP/CPAP therapy. Review of Resident R58's progress notes dated 2/18/24, 12:34 p.m., indicated the resident resting in bed this morning with CPAP on until about 9:00 a.m. when he woke up. Observation on 3/25/24, at 10:10 a.m., revealed a BiPAP/CPAP machine in Resident R58's room. Interview on 3/25/24, at 10:10 a.m., Resident R58 indicated they wear it at night for breathing. Interview on 3/28/24, at 9:56 a.m., the Director of Nursing DON2 confirmed the facility failed to make certain a physician order for use of, and cleaning of a Bi-PAP/CPAP machine, and failed to develop a plan of care for one of three residents (Resident R58). 28 Pa. Code 211.11(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, resident record review, and staff interviews, it was determined to facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of one residents (Resident R69). Findings include: Review of facility policy Trauma-Informed Care dated 1/23/24, indicated the facility will provide culturally competent, trauma-informed care across all disciplines to mitigate potential triggers for nursing residents who have experienced past or present trauma. Review of the clinical record indicated Resident R69 was admitted to the facility on [DATE]. Review of Resident R69's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/18/24, indicated diagnoses of high blood pressure, Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), and Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of Resident R69's care plan on 3/28/24, did not include a plan of care developed with goals and interventions related to post-traumatic stress disorder. During an interview on 3/28/24, at 9:26 a.m., Social Worker Employee E3 stated, I'm not sure why she has a PTSD diagnosis, I think it might be from an experience with her daughter, the allegation is that her daughter hit her. She is care planned for mood and behaviors, I thought it would be redundant to care plan her for PTSD. During an interview on 3/28/24, at 9:26 a.m., Social Worker Employee E3 confirmed that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on observations, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for five of five residents (Residents R6, R14, R31, R32, and R34). Findings include: Review of Title 42 Code of Federal Regulations (CFR) S483.25(n) - Bed Rails states that the facility must assess the resident for risk of entrapment from bed rails prior to installation. Additionally, there should be evidence in the resident's records that the facility performed ongoing assessments to assure that the bed rail is used to meet the resident's needs and that there is an ongoing evaluation of risks associated with bed rail usage. Review of facility policy Mobility Bars/Bedrails dated 1/23/24, indicated before a resident is fitted with mobility bars or bed rails, an interdisciplinary team must determine the presence of a specific medical symptom that would require the use of a bed rail and how that use would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychological wellbeing. On-going monitoring through the quarterly and/or with significant change assessment process will be used for evaluation of the reduction of restrictive devices in order to maintain the highest level of independence and safety. Review of the clinical record indicated that Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/18/24, indicated diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), overactive bladder (a problem with bladder function that causes the sudden need to urinate), and spinal stenosis (the space inside the bones of the spine get too small). Review of Resident R6s physician order dated 1/20/24, indicated mobility bars continuously. Review of Resident R6's care plan on 3/27/24, at 10:00 a.m., indicated bilateral (both sides) mobility bars for bed mobility. Review of Resident R6's clinical record on 3/27/24, at 10:00 a.m., failed to reveal an ongoing assessment of the mobility bars. Observation on 3/27/24, at 1:35 p.m., indicated Resident R6's bed with two mobility bars. Interview on 3/27/24, at 1:36 p.m., Nurse Aide (NA) Employee E9 confirmed Resident R6 had two mobility bars on the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated that Resident R14 was admitted to the facility on [DATE]. Review of Resident R14's MDS dated [DATE], indicated diagnoses of high blood pressure, heart failure (heart doesn't pump blood as well as it should), and coronary artery disease (narrow arteries decreasing blood flow to heart). Review of Resident R14's physician order dated 2/27/24, indicated left side mobility bar for bed mobility. Review of Resident R14's care plan on 3/27/24, at 10:05 a.m., indicated left mobility bar for bed mobility. Review of Resident R14's clinical record on 3/27/24, at 10:05 a.m., failed to reveal an ongoing assessment of the mobility bars. Observation on 3/27/24, at 1:36 p.m., indicated Resident R14's bed with one mobility bar on the left side of the bed. Interview on 3/27/24, at 1:36 p.m., NA Employee E9 confirmed Resident R14 had one mobility bar on the left side of the bed. Review of the clinical record indicated that Resident R31 was admitted to the facility on [DATE]. Review of Resident R31's MDS dated [DATE], indicated diagnoses Alzheimer ' s Disease (a progressive disease that destroys memory and other important mental functions), anxiety, and depression. Review of Resident R31's physician order dated 2/23/24, indicated bilateral mobility bars to aide in mobility. Review of Resident R31's care plan on 3/27/24, at 10:08 a.m., indicated bilateral mobility bars to aide in mobility. Review of Resident R31's clinical record on 3/27/24, at 10:08 a.m., failed to reveal an ongoing assessment of the mobility bars. Observation on 3/27/24, at 1:35 p.m., indicated Resident R31's bed with two mobility bars. Review of the clinical record indicated Resident R32 was admitted to the facility on [DATE]. Review of Resident R32's MDS dated [DATE], indicated diagnoses of history of falling, anemia (too little iron in the body causing fatigue), and dementia (a group of symptoms that affects memory and thinking, and interferes with daily life). Review of Section G: Functional Status, Question GG0170 indicated Resident R32 required substantial assistance with the helper doing more than half of the effort to complete bed mobility. Review of a physician order dated 8/17/22, indicated resident to use bilateral mobility bars to increase safety/independence with bed transfers and bed mobility. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R32's clinical record failed to reveal a current assessment for the continuation of mobility bar usage. An observation on 3/25/24, at 9:44 a.m., revealed mobility bars on both sides of Resident R32's bed. During an interview on 3/27/24, at 1:39 p.m., Registered Nurse (RN) Employee E2 confirmed Resident R32 had bilateral mobility bars applied to his bed. Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE]. Review of Resident R34's MDS dated [DATE], indicated diagnoses of high blood pressure, history of falling, and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). Review of Section G: Functional Status, Question GG0170 indicated Resident R34 required substantial assistance with the helper doing more than half of the effort to complete bed mobility. Review of a physician's order dated 7/15/21, indicated to apply mobility bars x 2 for assist with bed mobility. Review of Resident R34's clinical record failed to reveal a current assessment for the continuation of mobility bar usage. An observation on 3/25/23, at 9:38 a.m., revealed mobility bars on both sides of Resident R34's bed. During an interview on 3/27/24, at 1:35 p.m., Nurse Aide (NA) Employee E3 confirmed Resident R34 had bilateral mobility bars applied to her bed. During an interview on 3/27/24, at 1:08 p.m., Director of Nursing 1 (DON 1) confirmed that quarterly mobility bar assessments are not completed. During an interview on 3/27/24, at 1:40 p.m., DON 1 confirmed that the facility failed to conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for five of five residents (Residents R6, R14, R31, R32, and R34). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 211.12 (d) (1)(3)(5) Nursing services. 28 Pa. Code 211.10(c)(d) Resident care policies.

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly secure a medication drawer on four occasions in one of six households (Tionesta household). Findings include: Review of facility policy Medication Administration-General Guidelines, last reviewed 1/23/24, indicate during administration of medications, the medication cart /portable computer unit is kept closed and locked when out of sight of the medication nurse. During an observation on 3/26/24, 11:58 a.m., outside room [ROOM NUMBER] the portable computer unit medication drawer was left open, unattended, and out of site of the medication nurse. During an observation on 3/26/24, 12:10 p.m., outside room [ROOM NUMBER] the portable computer unit medication drawer was left open, unattended, and out of site of the medication nurse. During an interview on 3/26/24, at 12:17 p.m., Licensed Practical Nurse (LPN) Employee E7 confirmed the above findings. During an observation on 3/27/24, 8:40 a.m., outside room [ROOM NUMBER] the portable computer unit medication drawer was left open, unattended, and out of site of the medication nurse. During an observation on 3/27/24, 8:57 a.m., outside room [ROOM NUMBER] the portable computer unit medication drawer was left open and unattended and out of site of the medication nurse. During an interview on 3/27/24, 9:14 a.m., Licensed Practical Nurse (LPN) Employee E8 confirmed the above observation. During this interview, LPN Employee E8 acknowledged that Since I've been here, I know we lock the cabinets, I honestly don't know the policy concerning the drawer, I'm sure we are supposed to close/lock in between the residents. During an interview 3/27/24, 9:15 a.m., Clinical Nurse Manager stated, We don't usually close the drawer when in site, if leaving the area would shut and lock, I will call the Director of Nursing (DON) and ask. During an interview 3/27/24, 9:25 a.m., Director of Nursing (DON2) stated, the medication drawer on the portable computer units is to be shut and locked, the computer screen is to be closed and confirmed that the facility failed to secure a medication drawer in one of six households. 28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services. 28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395001	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Passavant Retirement and Healt	105 Burgess Drive Zelienople, PA 16063

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49469 Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to implement measures to prevent the potential for cross contamination during finger stick blood sugar monitoring for one of two residents (Resident R301) and failed to complete hand hygiene after a finger stick blood sampling on one of two residents (Resident R299) Findings include: Review of facility policy Hand Hygiene/Handwashing last reviewed on 1/23/24, indicate it is the policy of Passavant Community that all staff will follow the principles of good hand hygiene. Appropriate times to use hand hygiene include but are not limited to the following: - Before and after performing a task that includes hand washing in the procedure. For example, before and after performing a task that includes any invasive procedure, finger stick blood sampling, inserting urinary catheters, caring for vascular catheters, and changing dressing. Review of facility policy Diabetes-Glucometer last reviewed 1/23/24, indicate after completion of finger stick dispose of lancet, gloves and used strip in designated container, wash hands. Wipe glucometer off with a germicidal wipe. Review of Sani-cloth germicidal wipe instructions indicate unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two minutes, let air dry. During an observation of a medication pass on 3/26/24, at 11:58 a.m., Licensed Practical Nurse (LPN) Employee E7 obtained a finger stick blood sampling glucose reading from Resident R301, after cleaning the blood glucose monitor with a Sani-cloth wipe, Employee E7 placed the glucometer directly back into a black case, not allowing the glucometer to remain wet for a full two minutes and air dry. During an observation of a medication pass on 3/26/24, at 12:10 p.m. LPN Employee E7 obtained a finger stick blood sampling glucose reading from Resident R299, informed resident of reading and the required insulin per physician orders. Employee LPN E7 did not complete hand hygiene after completion of finger stick blood sampling prior to preparation of the insulin pen and insulin administration. During an interview on 3/26/27, at 12:17 p.m. LPN Employee E7 confirmed not allowing drying time after cleansing/sanitizing the glucometer after use for Resident R301, and did not complete hand hygiene after completion of finger stick blood sampling glucometer check for Resident R299 prior to preparation of the insulin pen and insulin administration. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.