STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395011	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Platinum Ridge Ctr for Rehab & Healing	1050 Broadview Boulevard Brackenridge, PA 15014

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documents, and staff interviews, it was determined that the facility failed to report an allegation of neglect within 24 hours to the local state field office for one of five residents (Resident R1). Findings include: Review of Residents R1's admission record indicated the resident was admitted on [DATE], and readmitted [DATE], with diagnoses of anemia (a condition in which the number of red blood cells is lower than normal), renal failure (occurs when the kidneys are no longer able to filter waste products from blood effectively), and osteoarthritis (a degenerative joint disease that occurs when the cartilage that cushions the joints wears down over time, leading to pain, stiffness, and loss of mobility.) Review of Residents R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/26/25, indicated the diagnoses were current. Review of Resident R1's progress note dated 4/14/25, indicated at 7:20 p.m. Licensed Practical Nurse (LPN), Employee E1 was called to Resident R1's room by Nurse Aide (NA), Employee E2. During care the resident rolled out of bed onto their knees while holding onto the bed rail. Resident R1 was assisted back to bed with an assist of three people and a Hoyer lift. No redness at this time to knees. Review of documentation provided to the local state field office from 4/14,25, to 5/6/25, did not include Resident R1's incident of neglect. During an interview on 5/28/25, at 11:22 a.m. the Director of Nursing confirmed the facility failed to report an allegation of neglect within 24 hours to the local state field office for one of five residents (Resident R1). 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interviews, it was determined that the facility failed to develop a comprehensive care plan to meet resident care needs for two of four residents (Resident R1 and R2), which resulted in harm, when a resident was rolled out of bed without the correct level of assistance and sustained bilateral leg fractures (Resident R1). Findings Include: Review of Residents R1's admission record indicated the resident was admitted on [DATE], and readmitted [DATE], with diagnoses of anemia (a condition in which the number of red blood cells is lower than normal), renal failure (occurs when the kidneys are no longer able to filter waste products from blood effectively), and osteoarthritis (a degenerative joint disease that occurs when the cartilage that cushions the joints wears down over time, leading to pain, stiffness, and loss of mobility.) Review of physician order dated 2/19/25, revealed Resident R1 transfers with a total assist of two persons via Hoyer lift, no ambulation. Review of Residents R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/26/25, indicated the diagnoses were current. Section GG- Functional Abilities revealed the resident was dependent with rolling left to right and required the assistance of two or more helpers. Review of Residents R1's care plan dated 8/24/22, revealed the resident used side rails for increased independence and mobility due to impaired bed mobility. Resident R1's care plan failed to indicate the level of assistance the resident required for bed mobility or transfers. Review of Resident R1's progress note dated 4/14/25, indicated at 7:20 p.m. Licensed Practical Nurse (LPN), Employee E1 was called to Resident R1's room by Nurse Aide (NA), Employee E2. During care the resident rolled out of bed onto their knees while holding onto the bed rail. The resident was on their right side while care was being provided and NA, Employee E2 was unable to stop the resident from rolling. Review of a late entry progress note dated 5/7/25, entered by RN, Employee E4 stated a bruise was observed to Resident R1's left distal superior knee. Bruise was dark/purple in color, approximately 9 cm x 5 cm x 0 cm. Resident denied recent trauma to area, the supervisor was notified. Review of a late entry progress note dated 5/7/25, at 12:04 p.m. entered by RN, Employee E5 indicated the physician saw the resident at bedside and wanted the resident to go to the hospital. A purple bruise was observed near the left knee. Resident denies pain. Review of Resident R1's physician order dated 5/7/25, indicated to complete an x-ray of the resident's left knee due to pain and bruise to rule out fracture. Review of Resident R1's progress note dated 5/7/25, at 7:49 p.m. revealed the resident's left knee was fractured. The physician and family were notified and the resident was transferred to the hospital for further evaluation. (continued on next page)

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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 0656 Level of Harm - Actual harm Residents Affected - Few	Review of progress note dated 5/8/25, at 3:00 a.m. revealed Resident R1 was admitted to the hospital. The resident's x-ray results shows bilateral leg fractures. The resident's hemoglobin (a red protein responsible for transporting oxygen in the blood, normal value in women is 11.6 to 15 grams per deciliter. A hemoglobin level less than 6.5 can be life threating) level was 5.1 and required a blood transfusion. During an interview on 5/28/25, at 9:56 a.m. Physical Therapist, Employee 10 confirmed the facility failed to ensure Resident R1's care plan had the level of assistance required for bed mobility on 4/14/25. Review of Resident R1's investigation on 5/28/25, at 10:45 a.m. revealed on 5/9/25, Resident R1 was interviewed. Resident R1 was asked Do you know what happened that caused the fractures to your legs? Resident R1 answered Yes, it happened when I rolled out of bed a few weeks ago. During an interview on 5/28/25, at 12:07 p.m. Nurse Aide (NA), Employee E2 conifrmed Resident R1's bed mobility was not available on the [NAME] (a documentation system that enables nurses to write, organize, and easily reference key patient information that shapes their nursing care plan.) when Resident R1 rolled out of bed on 4/14/25. Review of Resident R2's clinical record revealed the resident was admitted to the facility on [DATE], and had a diagnosis of muscle weakness, ataxic gait (problem with coordinating muscle movements), and obesity. Review of Resident R2's physician orders dated 5/26/25, revealed the resident transfers with a total assist of two via Hoyer lift, no ambulation. Review of Resident R2's clinical record on 5/28/25, at 11:41 a.m. failed to include a care plan for the resident's transfer status. During an interview on 5/28/25, at 11:41 a.m. [NAME] President (VP) of Rehab, Employee E9 confirmed Resident R2 failed to have a care plan for transfer status or bed mobility. During an interview on 5/28/25, at 2:04 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to develop a comprehensive care plan to meet resident care needs for two of four residents (Resident R1 and R2), which resulted in harm, when a resident was rolled out of bed without the correct level of assistance and sustained bilateral leg fractures (Resident R1). 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(5) Nursing services

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, and staff interviews it was determined that the facility failed to provide appropriate care and treatment for one of four residents (Residents R1), which resulted in harm, and Resident R1 required a blood transfusion. Findings include: Review of the facility policy Falls-Clinical Protocol dated 3/4/25, last reviewed 5/19/25, indicated the staff, with the physician guidance, will follow up on any fall with associated injury until the resident is stable. Review of the facility policy Change in a Resident's Condition or Status dated 3/4/25, last reviewed 5/19/25, indicated the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been a discovery of injuries of unknown source, significant change in the resident's physical condition, and need to alter the resident's medical treatment significantly. A significant change of condition is a major decline in the resident's status that will not normally resolve itself without intervention by staff or by implementing interventions. Review of Residents R1's admission record indicated the resident was admitted on [DATE], and readmitted [DATE], with diagnoses of anemia (a condition in which the number of red blood cells is lower than normal), renal failure (occurs when the kidneys are no longer able to filter waste products from blood effectively), and osteoarthritis (a degenerative joint disease that occurs when the cartilage that cushions the joints wears down over time, leading to pain, stiffness, and loss of mobility.) Review of Residents R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/26/25, indicated the diagnoses were current. Review of Residents R1's care plan dated 8/24/22, revealed the resident was at risk for bleeding secondary to anticoagulant (blood thinner) use. Interventions included to observe effectiveness of medication given and observe for adverse reactions, observe for signs and symptoms of bleeding such as skin bruising, and to check labs and notify physician of abnormal findings. Review of physician order dated 4/4/25, indicated to administer two tablets of 1 milligram (mg) of Warfarin (also known as Coumadin, a blood thinning medication that reduces formation of blood clots) at bedtime every Thursday, Friday, Saturday, and Sunday for atrial fibillation (abnormal heart rhythm). Review of Resident R1's progress note dated 4/14/25, indicated at 7:20 p.m. Licensed Practical Nurse (LPN), Employee E1 was called to Resident R1's room by Nurse Aide (NA), Employee E2. During care the resident rolled out of bed onto their knees while holding onto the bed rail. Resident R1 was assisted back to bed with an assist of three people and a Hoyer lift. No redness at this time to knees. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R1's progress note dated 4/14/25, at 7:47 p.m. revealed Registered Nurse (RN), Employee E3 was called to the unit by staff. Resident R1 was observed lying on the floor. The resident stated I slid out of bed and was on my knees with my legs underneath me. The resident denied any pain to bilateral lower extremities. The physician was notified. Review of Resident R1's late entry progress note dated 4/14/25, at 4:48 a.m. indicated Resident R1 was complaining of being sore from the fall. The Director of Nursing advised Licesned Practical Nurse (LPN), Employee E12 to administer two tablets of 325 milligram (mg) Tylenol by mouth for pain. Medication was administered. Further review of clinical record failed to reveal a physician was notified of Resident R1's pain and an order for Tylenol was obtained. Review of Resident R1's progress note dated 4/15/25, at 1:26 p.m. revealed the resident requested to speak with the Director of Nursing and RN Supervisor. Resident R1 was requesting an as needed Tylenol order for pain. The order for Tylenol was pending approval. Review of Resident R1's physician order dated 4/15/25, indicated to administer two tablets of 325 mg Tylenol every four hours as needed for mild pain. The physician order failed to include a pain scale. Review of Resident R1's progress note dated 4/15/25, at 7:24 p.m. stated Bruising to right shin present and left abdomen. Resident is on Coumadin. Further review failed to indicate the physician was notified of Resident R1's right shin and left abdomen bruising. Review of clinical record revealed Resident R1 had bruising noted to the right shin on the following days with no evidence the physician was notified of the symptoms of bleeding: -4/16/25 -4/17/25 -4/18/25 -4/21/25 -4/22/25 -4/23/25 -4/24/25 -4/25/25 -4/26/25 -4/29/25 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of physician order dated 4/25/25, indicated to obtain PT (Prothrombin time-the amount of time it takes for the blood to clot) and INR (International Normalized Ratio (INR-a specific blood test used to measure the time it takes for blood to form a blood clot, normal value for someone taking anticoagulant is between 2 and 3.5)) one time only for monitoring on 5/2/25. Review of Resident R1's lab results dated 5/2/25, revealed the resident's INR was critical at 7.2 A recommendation of an INR of 2.0 to 3.0 is made for all indications for oral anticoagulation except mechanical prosthetic heart valves and prevention of recurrent myocardial infarction for which an INR of 2.5 to 3.5 is recommended. It was indicated the lab notified Medical Director, Employee E11 on 5/2/25, at 9:08 a.m. of Resident R1's critical INR result. Review of physician order dated 4/4/25, to administer two tablets of 1 mg of Warfarin was discontinued on 5/2/25. Review of physician order dated 5/2/25, indicated to obtain PT/INR one time only for monitoring on 5/5/25. Review of Resident R1's progress note dated 5/5/25, revealed the resident had several bruises located on both legs. There was no evidence a physician was notified of signs and symptoms of abnormal bleeding such as bruising as the care plan indicated. Review of Resident R1's lab results dated 5/5/25, revealed the resident's INR was critical at 8.7. It was indicated the lab notified the Medical Director, Employee E11 on-call on 5/5/25, at 3:08 p.m. Review of Resident R1's clinical record from 5/5/25, to 5/7/25, failed to include evidence of the interventions that were implemented related to Resident R1's critical INR lab value, and failed to include evidence of the physicain repsonse related to Resident R1's critical INR lab value. Review of a late entry progress note dated 5/7/25, entered by RN, Employee E4 stated a bruise was observed to Resident R1's left distal superior knee. Bruise was dark/purple in color, approximately 9 cm x 5 cm x 0 cm. Nurse Aide stated that resident began refusing care on 5/6/25, due to pain in left leg. Resident denied recent trauma to area, the supervisor was notified. Review of Resident R1's physician order dated 5/7/25, indicated to complete an x-ray of the resident's left knee due to pain and bruise to rule out fracture. Review of a late entry progress note dated 5/7/25, at 12:04 p.m. entered by RN, Employee E5 indicated the physician saw the resident at bedside and wanted the resident to go to the hospital. Pro lab reported an INR 8.0. and Coumadin on hold. A purple bruise was observed near the left knee. The physician gave an order for Vitamin K 5 mg daily, for two days. The facility failed to timely address Resident R1's critical INR result. Review of Resident R1's progress note dated 5/7/25, at 7:49 p.m. revealed the resident's left knee was fractured. The physician and family were notified and the resident was transferred to the hospital for further evaluation. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of progress note dated 5/8/25, revealed Resident R1 was admitted to the hospital. The resident's hemoglobin (a red protein responsible for transporting oxygen in the blood, normal value in women is 11.6 to 15 grams per deciliter. A hemoglobin level less than 6.5 can be life threatening) level was 5.1 and Resident R1 required a blood transfusion. Review of Resident R1's hospital records dated 5/8/25, stated the resident evidently had a fall on 4/14/25, when nursing staff inadvertently lost hold of the resident and the resident fell out of bed. Ecchymosis (medical term for a type of bruise that occurs when blood leaks out of blood vessels into the subcutaneous tissue beneath the skin, often caused by trauma) was observed to the resident's left anterior knee, right knee and skin with some bruising of the right ankle. The resident's INR was supratherapeutic for the past few days. Resident R1 INR was 7.0. The resident's hemoglobin was 5.1. The resident received two units of red blood cells. Review of a late entry progress note created on 5/18/25, effective 4/16/25, entered by Medical Director, Employee E11 indicated the resident was seen for follow up care. The resident had recent hospital admission for sepsis. There was no evidence Resident R1's bruising to the right shin was addressed. During an interview on 5/28/25, at 9:44 a.m. LPN, Employee E8 indicated if a resident has a change in condition the supervisor is made aware and the physician is notified. It was indicated any change in condition is documented in the clinical record with the physician response. During an interview on 5/28/25, at 2:03 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to provide appropriate care and treatment for one of four residents (Residents R1), which resulted in harm, and Resident R1 required a blood transfusion. 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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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, and staff interviews it was determined that the facility failed to ensure the appropriate assistance for bed mobility was provided for one of four residents (Residents R1), which resulted in harm when Resident R1 rolled out of bed and sustained bilateral leg fractures. Findings include: Review of the facility policy Repositioning dated 3/4/25, reviewed 5/19/25, stated the purpose of the procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, and to promote comfort for all bed or chair bound residents. Review the resident's care plan to evaluate for any special needs of the resident. Review of the facility policy Safe Lifting and Movement of Residents dated 3/4/25, reviewed 5/19/25, stated in order to protect the safety and well-being of staff and residents, and to promote quality care, the facility uses appropriate techniques and devices to lift and move extremities. Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding safe lifting and moving of residents. Manual lifting of residents shall be eliminated when feasible. Nursing staff in conjunction with the rehabilitation staff, shall assess individual resident's needs for transfer assistance on an ongoing basis. Staff will document transferring and lifting needs in the care plan. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary. Review of the facility policy Falls-Clinical Protocol dated 3/4/25, last reviewed 5/19/25, indicated the staff, with the physician guidance, will follow up on any fall with associated injury until the resident is stable and related complications such as late fractures have been ruled out or resolved. Delayed complications such as late fractures and major bruising may occur hours or days after a fall. Review of the facility policy Change in a Resident's Condition or Status dated 3/4/25, last reviewed 5/19/25, indicated the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been a discovery of injuries of unknown source, significant change in the resident's physical condition, and need to alter the resident's medical treatment significantly. A significant change of condition is a major decline in the resident's status that will not normally resolve itself without intervention by staff or by implementing interventions. Review of Residents R1's admission record indicated the resident was admitted on [DATE], and readmitted [DATE], with diagnoses of anemia (a condition in which the number of red blood cells is lower than normal), renal failure (occurs when the kidneys are no longer able to filter waste products from blood effectively), and osteoarthritis (a degenerative joint disease that occurs when the cartilage that cushions the joints wears down over time, leading to pain, stiffness, and loss of mobility.) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of physician order dated 2/19/25, revealed Resident R1 transfers with a total assist of two persons via Hoyer lift, no ambulation. Review of Residents R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/26/25, indicated the diagnoses were current. Section GG- Functional Abilities revealed the resident was dependent with rolling left to right and required the assistance of two or more helpers. Review of Residents R1's care plan dated 8/24/22, revealed the resident used side rails for increased independence and mobility due to impaired bed mobility. Resident R1's care plan failed to indicate the level of assistance the resident required for bed mobility or transfers. Review of Resident R1's progress note dated 4/14/25, indicated at 7:20 p.m. Licensed Practical Nurse (LPN), Employee E1 was called to Resident R1's room by Nurse Aide (NA), Employee E2. During care the resident rolled out of bed onto their knees while holding onto the bed rail. The resident was on their right side while care was being provided and NA, Employee E2 was unable to stop the resident from rolling. The resident was turned onto their back and a pillow was placed under their head. The supervisor was called to the room. The resident had a 2-centimeter (cm) x 1 cm abrasion to inner side of the right foot. Resident R1 was assisted back to bed with an assist of three people and a Hoyer lift. No redness at this time to knees. Review of Resident R1's progress note dated 4/14/25, at 7:47 p.m. revealed Registered Nurse (RN), Employee E3 was called to the unit by staff. Resident R1 was observed lying on the floor. The resident stated I slid out of bed and was on my knees with my legs underneath me. The resident denied any pain to bilateral lower extremities. The physician was notified. Review of Resident R1's late entry progress note dated 4/14/25, at 4:48 a.m. indicated Resident R1 was complaining of being sore from the fall. Review of Resident R1's physician order dated 4/15/25, indicated to complete a stat x-ray of the resident's right foot and ankle due to fall. Review of Resident R1's progress note dated 4/15/25, revealed the x-ray was completed at the resident's bedside at 6:30 p.m. of the right foot and ankle. Bruising to right shin present and left abdomen. There was no documentation of the size/measurement of brusing. Resident is on Coumadin. Further review failed to indicate the physician was notified of Resident R1's right shin and left abdomen bruising. Review of Resident R1's progress note dated 4/15/25, at 7:41 p.m. indicated Resident R1's x-rays were negative for fractures of the right foot and ankle. Review of Resident R1's progress notes had bruising, that was not measured, observed to the right shin on the following days with no evidence the physician was notified: -4/16/25 -4/17/25 -4/18/25 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-4/21/25 -4/22/25 -4/23/25 -4/24/25 -4/25/25 -4/26/25 -4/29/25 Review of Resident R1's progress noted dated 5/5/25, revealed an assist of two staff members were used to reposition the resident. The resident asked for pain medication at the beginning of the shift. Resident R1 was provided 650 mg of Tylenol for 3/10 right knee pain (pain scale that grades pain levels from 0 (No pain), 1,2, and 3 (Mild), 4,5, and 6 (Moderate), 7,8, and 9 (Severe) to 10 (Worst Pain Possible)). It was indicated the resident had several bruises located on both legs. Review of a late entry progress note dated 5/7/25, at 11:33 a.m. entered by RN, Employee E4 stated a bruise was observed to Resident R1's left distal superior knee. Bruise was not observed during treatment on 5/5/25. Bruise was dark/purple in color, approximately 9 cm x 5 cm x 0 cm. Nurse Aide (unidentified) stated that resident began refusing care on 5/6/25, due to pain in left leg. Resident denied recent trauma to area, the supervisor was notified. Review of a late entry progress note dated 5/7/25, at 12:04 p.m.entered by RN, Employee E5 indicated the physician examined the resident at bedside and wanted the resident to go to the hospital. A purple bruise was observed near the left knee. Resident denies pain. Review of Resident R1's physician order dated 5/7/25, indicated to complete an x-ray of the resident's left knee due to pain and bruise to rule out fracture. Review of Resident R1's progress note dated 5/7/25, at 7:49 p.m. revealed the resident's left knee was fractured. The physician and family were notified, and the resident was transferred to the hospital for further evaluation. Review of progress note dated 5/8/25, revealed Resident R1 was admitted to the hospital. The resident's x-ray results show bilateral leg fractures. The resident's hemoglobin (red protein responsible for transporting oxygen in the blood, normal value in women is 11.6 to 15 grams per deciliter. A hemoglobin level less than 6. 5 can be life threating) level was 5.1 and required a blood transfusion. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395011	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Platinum Ridge Ctr for Rehab & Healing	1050 Broadview Boulevard Brackenridge, PA 15014

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R1's hospital records dated 5/8/25, stated the resident evidently had a fall on 4/14/25, when nursing staff inadvertently lost hold of the resident and the resident fell out of bed. The resident had extensive bruising to the right knee and is non-ambulatory and bed-bound at baseline. Tenderness along the left anterior knee diffusely associated with ecchymosis (medical term for a type of bruise that occurs when blood leaks out of blood vessels into the subcutaneous tissue beneath the skin, often caused by trauma), ecchymosis of the right knee and skin with some bruising of the right ankle was observed. The resident sustained a left distal femur fracture and a right tibial plateau fracture (a break of the upper part of the shinbone that involves the knee joint.) The resident's International Normalized Ratio (INR-a specific blood test used to measure the time it takes for blood to form a blood clot, normal value for someone taking anticoagulant is between 2 and 3.5) was 7.0 and hemoglobin was 5.1. The resident received two units of red blood cells. Review of information submitted to the Department of Health on 5/8/25, indicated on 5/6/25, Resident R1 complained of pain to the left leg. The physician ordered an x-ray of the left knee and it was confirmed the resident had a fracture. The resident was sent to the hospital for further evaluation. It was revealed the resident thinks the fractures occurred from being rolled out of bed with an assist of one person on 4/14/25. From 4/14/25, to 5/6/25, the resident had mild pain that was relieved by Tylenol. Abuse was ruled out and unsubstantiated. Prior to the incident bed mobility was not care planned for the resident. Review of a late entry progress note created on 5/18/25, effective 4/16/25, entered by Medical Director, Employee E11 indicated the resident was seen for follow up care. The resident had recent hospital admission for sepsis. There was no evidence Resident R1's fall or bruising to the right shin was addressed. During an interview on 5/28/25, at 9:12 a.m. the Nursing Home Administrator (NHA) stated what happened to Resident R1 was really a terrible accident. During an interview on 5/28/25, at 9:41 a.m. NA, Employee E6 stated if a resident is ordered to be transferred with an assist of two, then two people must assist the resident with bed mobility. Residents should be rolled towards the person rolling them. During an interview on 5/28/25, at 9:44 a.m. LPN, Employee E7 indicated physician orders should be entered for resident's transfer status and bed mobility. During an interview on 5/28/25, at 9:54 a.m. Occupational Therapist, Employee E8 stated when residents are admitted they are assessed by physical therapy within 48 hours. Nursing staff puts an order for an assist of two until evaluated by therapy. OT, Employee E8 stated every resident should have an order for bed mobility and transfer status. During an interview on 5/28/25, at 9:56 a.m. Physical Therapist, Employee E10 indicated typically bed mobility and transfers orders are not usually entered as separate orders unless necessary. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/28/25, at 11:41 a.m. [NAME] President (VP) of Rehab, Employee E9 stated once therapy evaluates a resident, therapy enters the order for the resident's transfer status. Typically bed mobility and transfer status orders are entered as one order, however if there are special requirements, separate orders for bed mobility and transfer status are entered. When asked what level of bed mobility Resident R1 required, VP of Rehab stated maximum to dependent. It is kind of confusing, therapy language is different than nursing. Review of the facility's investigation on 5/28/25, NA, Employee E2 indicated while changing Resident R1, NA, Employee E2 was putting a new lift sheet under the resident, and the resident kept rolling back over onto their back. NA, Employee E2 placed their hand on the resident's back to hold the resident on their side. The resident started moving their feet closer to the edge of the bed. NA, Employee E2 noticed the resident's feet going off the bed and the resident lowered themselves to the floor on their knees. During an interview on 5/28/25, at 12:07 p.m. NA Employee E2 indicated bed mobility and transfers status can be found in a resident's [NAME]. NA, Employee E2 stated If the bed mobility is not indicated on the [NAME], it depends on how much the resident can assist in the transfer for the level of assistance required. It depends on how much you pay attention to residents, if the resident is able to hold on to the rails or able to roll. When asked what occurred on 4/14/25, NA, Employee E2 stated Resident R1 does not want to do anything, wants to lay there, easier for [him/her] to have two people. NA, Employee E2 had been taking care of Resident R1 for a year. NA, Employee E2 stated Resident R1 was already mad that day, and the resident said I don't know why you can't get someone so I can roll over. NA, Employee E2 was putting a fresh sheet under the resident, and the resident kept flopping back over. NA, Employee E2 stated I told Resident R1 I only need two minutes. The resident then moved their feet closer to the edge of the bed and was hugging the rail. Resident R1 slid out of bed. During an interview on 5/28/25, at 2:03 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to ensure the appropriate assistance for bed mobility was provided for one of four residents (Residents R1), which resulted in harm when Resident R1 rolled out of bed and sustained bilateral leg fractures. 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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interviews with staff, it was determined that the facility did not ensure that a physician assessment was timely completed after a fall for one of four residents reviewed (Resident R1). Findings include: Review of Residents R1's admission record indicated the resident was admitted on [DATE], and readmitted [DATE], with diagnoses of anemia (a condition in which the number of red blood cells is lower than normal), renal failure (occurs when the kidneys are no longer able to filter waste products from blood effectively), and osteoarthritis (a degenerative joint disease that occurs when the cartilage that cushions the joints wears down over time, leading to pain, stiffness, and loss of mobility.) Review of Residents R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/26/25, indicated the diagnoses were current. Review of Resident R1's progress note dated 4/14/25, indicated at 7:20 p.m. Licensed Practical Nurse (LPN), Employee E1 was called to Resident R1's room by Nurse Aide (NA), Employee E2. During care the resident rolled out of bed. Review of clinical record revealed Resident R1 had bruising noted to the right shin on the following days: -4/16/25 -4/17/25 -4/18/25 -4/21/25 -4/22/25 -4/23/25 -4/24/25 -4/25/25 -4/26/25 -4/29/25 Review of progress note dated 5/8/25, revealed Resident R1 was admitted to the hospital. The resident's hemoglobin (a red protein responsible for transporting oxygen in the blood, normal value in women is 11.6 to 15 grams per deciliter. A hemoglobin level less than 6.5 can be life threating) level was 5.1 and Resident R1 required a blood transfusion. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R1's hospital records dated 5/8/25, stated the resident evidently had a fall on 4/14/25, when nursing staff inadvertently lost hold of the resident and the resident fell out of bed. Ecchymosis (medical term for a type of bruise that occurs when blood leaks out of blood vessels into the subcutaneous tissue beneath the skin, often caused by trauma) was observed to the resident's left anterior knee, right knee and skin with some bruising of the right ankle. The resident's INR was supratherapeutic for the past few days. Resident R1 INR was 7.0. The resident's hemoglobin was 5.1. The resident received two units of red blood cells. Review of a late entry progress note created on 5/18/25, effective 4/16/25, entered by Medical Director, Employee E11 indicated the resident was seen for follow up care. There was no evidence Resident R1's fall or bruising to the right shin was addressed. During an interview on 5/28/25, at 2:03 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to ensure that a physician assessment was timely completed after a fall for one of four residents reviewed (Resident R1). 28 Pa. Code: 211.12(d)(5) Nursing services. 28 Pa. Code: 211.2(a) Physician services. 28 Pa. Code: 211.5(f) Clinical records.