

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Platinum Ridge Ctr for Rehab & Healing		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</b></p> <p>Based on review of facility policy, observations, resident interview, and employee interviews it was determined that the facility failed to accommodate the needs of a resident with a visual impairment for one of two residents (Resident R32).</p> <p>Findings include:</p> <p>Review of admission record indicated Resident R32 was admitted to the facility on [DATE], with diagnoses of anxiety, depression, and muscle weakness.</p> <p>Review of the Minimum Data Set (MDS-periodic assessment of care needs) dated 5/17/24, indicated the diagnoses were current. Review of section GG: Function Abilities and Goals indicated Resident R32 requires set-up and clean-up assistance with eating.</p> <p>Review of Resident R32's care plan dated 7/17/24, indicated the resident has impaired visual function due to macular degeneration (an eye disease that affects central vision).</p> <p>During an interview on 8/4/24, at 9:37 a.m. Resident R32 stated she went blind about two months ago. Resident R32 indicated staff leave her meal trays on her table, and some staff don't tell her what's on her tray. Resident R32 stated I have to know what I am eating and where it's at.</p> <p>During an observation on 8/4/24, at 12:11 p.m. Licensed Practical Nurse (LPN), Employee E25 was observed assisting Resident R32 with her lunch in her room. LPN, Employee E25 failed to describe where items were located on the resident's tray.</p> <p>During an interview on 8/4/24, at 12:13 p.m. LPN, Employee E25 indicated she was aware of Resident R32's visual impairment and confirmed she failed to describe where items were on her meal tray. LPN, Employee E25 confirmed the facility failed to accommodate the needs of a resident with a visual impairment for one of two residents (Resident R32).</p> <p>28 Pa. Code: 201.20(c) Staff development.</p> <p>28 Pa. Code: 201.29(j) Resident rights.</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on review of facility policies, clinical records, facility submitted documents, observations, and staff interview, it was determined that the facility failed to provide services to create an environment free from neglect for one of six residents (Resident R29).</p> <p>Findings include:</p> <p>Review of facility policy Pressure Ulcers/Skin Breakdown-Clinical Protocol last reviewed 8/24/23, indicated the physician will order pertinent wound treatments, and guide the care plan as appropriate.</p> <p>Review of facility policy Wound Care dated 8/24/23, indicated the following information should be recorded in the resident's medical record: the type of wound care given, the date and time the wound care was given, the name and title of the individual performing the wound care, if the resident refused the treatment and the reason(s) why, and the signature and title of the person recording the data.</p> <p>Review of Resident R29's clinical record indicated the resident was admitted [DATE].</p> <p>Review of Resident R29's Minimum Data Set (MDS- a periodic assessment of resident care needs) dated 5/6/24, indicated diagnoses of quadriplegia (paralysis that affects all limbs and body from the neck down), anxiety, and depression.</p> <p>Review of Resident R29's care plan dated 5/7/24, indicated the resident had actual skin breakdown related to pressure injury of left distal index finger. Interventions included to administer treatment per physician orders.</p> <p>Review of Resident R29's physician order dated 7/3/24, indicated to cleanse the second finger to left hand with normal saline solution (solution used to clean wounds), pat dry, apply Medihoney (type of wound gel that has antibacterial and bacterial resistant properties), and cover with a small border gauze dressing once a day in the evening shift for wound care and as needed.</p> <p>During an observation 8/5/24, at 10:09 a.m. Resident R29's wound dressing to her left index finger was dated 8/2/24.</p> <p>During an interview on 8/5/24, at 10:10 a.m. Licensed Practical Nurse (LPN), Employee E17 confirmed Resident R29's dressing was dated 8/2/24, and the facility failed to complete the resident's dressing as ordered.</p> <p>During an interview on 8/5/24, at 10:18 a.m. Registered Nurse Supervisor, Employee E16 stated treatment orders are documented in the Treatment Administration Record, and the physician order indicates how often the dressing must be completed. If the dressing is not signed off for completion in the TAR, then a progress note must be entered indicating the reason the dressing was not completed, then a supervisor must be notified.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/5/24, at 10:22 a.m. the Director of Nursing confirmed that the facility failed to provide services to create an environment free from neglect for Resident R29 as required.</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa Code: 201.18 (e)(1) Management.</p> <p>28 Pa Code: 211.10 (c)(d) Resident care policies.</p> <p>28 Pa Code: 211.11 Resident care plan.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</b></p> <p>Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents for one of two residents (Resident R47), and failed to properly screen an employee by completing a State background check prior to hire for two of five personnel records (Nursing Assistant (NA) Employee E19 and Registered Nurse (RN) Employee E20).</p> <p>Findings include:</p> <p>Review of facility policy Abuse and Neglect - Clinical Protocol dated 8/24/23, indicated neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The staff, with the physician's input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes.</p> <p>Review of facility policy Background Screening Investigations dated 8/24/24, indicated that the facility conducts employment background screenings, checks, reference checks, and criminal conviction investigations checks on individuals making application for employment with our facility. Such investigations will be initiated prior to hire or offer of employment.</p> <p>Review of the clinical record indicated Resident R47 was admitted to the facility on [DATE].</p> <p>Review of Resident R47's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/10/24, indicated diagnoses of high blood pressure, atrial fibrillation (disease of the heart characterized by irregular an often faster heartbeat), and anemia (too little iron in the body causing fatigue).</p> <p>Review of a nursing progress note dated 5/24/24, at 6:46 a.m. completed by Licensed Practical Nurse (LPN) Employee E9 stated, Was called into Residents [Resident R47] room by Nurse Aide (NA). NA reports some bruising on residents right and left breast and left abdominal areas, both lower and upper. When asked resident what happened she stated, NA Employee E1 and another large girl were taking her out of the chair and transferring her to the bed when they grabbed both armpits and pulled her up. She then stated, Please stop you're hurting breaking my arms! Resident stated, Both NAs said 'you're almost to the bed, you're fine'.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a nursing progress note dated 5/24/24, at 7:45 a.m. completed by Registered Nurse (RN) Employee E10 stated, Resident was assessed by this writer this morning when charge nurse reported this resident had bruises to both of her breasts. On assessment a 23 cm (centimeter) L (length) x 5 cm W (width) dark purple in color bruise is observed to her left lower breast area. The skin is intact, no swelling or redness is present. Resident's right lower breast area is observed with a 16 cm L x 6 cm W dark purple in color bruise. No swelling or redness is present. Also a 9.0 cm L x 2 cm W red and purple in color bruise is present to resident's right upper outer abdominal area and a 7.0 cm L x 1.0 cm W red and purple in color bruise is present directly below the first abdominal bruise. Resident states areas are painful. Resident receives Eliquis (a blood thinner) 2.5 mg (milligrams) BID (twice a day). Therapy to be consulted to evaluate transfer. Resident educated to inform staff when any situation occurs for resident's safety. Resident stated, I didn't tell my parents. I don't want trouble. Staff to monitor bruising and report any changes to MD (physician). MD notified by fax. Family to be notified this morning.</p> <p>Review of a witness statement dated 5/27/24, completed by NA Employee E1 stated, Resident R47 was complaining on Monday evening that the side of her breasts were hurting. I said you're leaning on the side of your wheelchair, so another NA and I help her into bed. When I helped Resident R47 put her gown on she had no bruising. The next time I was here was Wednesday. I had to get Resident R47's weight. I was helping Physical Therapy transfer Resident R47 into the wheelchair. She said before you put me into the chair, I'm very sore on my upper body. That night, NA Employee E2 and I put Resident R47 to bed. NA Employee E2 had her upper half under her arms and I had Resident R 47's pants. Resident R47 was hanging on the side row and we put her into bed. Prior to that, Resident R47 was hanging on both side of her wheelchair with her arm down dangling over the metal part of the wheelchair. That when NA Employee E2 and I put her into bed she was going to fall out of the chair leaning on both side of the chair.</p> <p>Review of a witness statement dated 5/29/24, completed by NA Employee E2 stated, On Wednesday May 22, 2024 I worked the back section assignment on the third floor on the 3 p.m. to 11 p.m. shift. Resident R47 was not in my assignment however her NA for the night asked for assistance in changing her for last rounds before I had to go downstairs to assist another aide in last rounds because she was alone and had an admission come in. NA Employee E1 and I went into her [Resident R47] room, transferred her from her wheelchair by stand pivot to bed slowly, rolled her from side to side to clean her up for bed. NA Employee E1 finished up in Resident R47's room and I headed downstairs to the first floor.</p> <p>During an interview on 8/5/24, at 10:14 a.m. NA Employee E4 stated, If resident was yelling out in pain during a transfer, I would ask them what is hurting them and try to address it. I would report it to the nurse on duty, I would let them know so they can come back and assess the resident.</p> <p>During an interview on 8/5/24, at 10:19 a.m. NA Employee E1 stated, If a resident was yelling out in pain during a transfer, I would put them back down and ask what is hurting, try to figure it out. I would report it to the charge nurse and pass it on in my report.</p> <p>During an interview on 8/5/24, at 10:38 a.m. NA Employee E5 stated, If a resident was yelling out in pain during a transfer, I would complete the transfer and then try to figure out what was hurting. I would report it to the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/8/24, at 10:02 a.m. the Director of Nursing (DON) confirmed that NA Employee E1 and NA Employee E2 did not report to the staff nurse or the nurse supervisor that Resident R47 had verbalized pain during a manual transfer on 5/22/24.</p> <p>During an interview on 8/8/24, at 10:02 a.m. the DON confirmed that the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents for one of two residents (Resident R47).</p> <p>Review of NA Employee E19's personnel record indicated she was hired on 4/19/24.</p> <p>Review of NA Employee E19 ' s personnel record did not reveal that a Pennsylvania criminal background check was completed prior to her start date of employment.</p> <p>During an interview on 8/5/24, at 3:58 p.m. LPN Employee E7 confirmed that the criminal background check was not completed prior to start date.</p> <p>Review of RN Employee E20's personnel record indicated she was hired 7/2/24.</p> <p>Review of RN Employee E20' s personnel record did not reveal that a Pennsylvania criminal background check was completed prior to her start date of employment.</p> <p>During an interview on 8/5/24, at 3:58 p.m. LPN Employee E7 confirmed that the criminal background check was not completed prior to start date.</p> <p>During an interview on 8/6/24, at m the Nursing Home Administrator confirmed that the facility failed to properly screen an employee by completing a state background check prior to hire for two of five personnel records (NA Employee E519 and RN Employee E20).</p> <p>28 Pa Code: 201.14(a) (c)(d)(e) Responsibility of licensee</p> <p>28 Pa Code: 201.19 Personnel policies and procedures</p> <p>28 Pa Code: 201.20 (a)(b)(c)(d) Staff development</p> <p>28 Pa Code: 201.29 (d) Resident Rights</p> <p>28 Pa Code 201.18(b)(1)(2)(e)(1) Management.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</b></p> <p>Based on review of facility policy, clinical record review, investigation documentations, and staff interviews, it was determined that the facility failed to conduct a thorough investigation to rule out neglect for one of two residents (Resident R47).</p> <p>Findings include:</p> <p>Review of facility policy Abuse and Neglect - Clinical Protocol dated 8/24/23, indicated neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The staff, with the physician's input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes.</p> <p>Review of the clinical record indicated Resident R47 was admitted to the facility on [DATE].</p> <p>Review of Resident R47's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/10/24, indicated diagnoses of high blood pressure, atrial fibrillation (disease of the heart characterized by irregular an often faster heartbeat), and anemia (too little iron in the body causing fatigue).</p> <p>Review of a nursing progress note dated 5/24/24, at 6:46 a.m. completed by Licensed Practical Nurse (LPN) Employee E9 stated, Was called into Residents [Resident R47] room by Nurse Aide (NA). NA reports some bruising on residents right and left breast and left abdominal areas, both lower and upper. When asked resident what happened she stated, NA Employee E1 and another large girl were taking her out of the chair and transferring her to the bed when they grabbed both armpits and pulled her up. She then stated, Please stop you're hurting breaking my arms! Resident stated, Both NAs said 'you're almost to the bed, you're fine'.</p> <p>Review of facility investigation documentation indicated that the alleged perpetrators were identified as NA Employee E1 and NA Employee E2.</p> <p>Review of a witness statement dated 5/27/24, completed by NA Employee E1 stated, Resident R47 was complaining on Monday evening that the side of her breasts were hurting. I said you're leaning on the side of your wheelchair, so another NA and I help her into bed. When I helped Resident R47 put her gown on she had no bruising. The next time I was here was Wednesday. I had to get Resident R47's weight. I was helping Physical Therapy transfer Resident R47 into the wheelchair. She said before you put me into the chair, I'm very sore on my upper body. That night, NA Employee E2 and I put Resident R47 to bed. NA Employee E2 had her upper half under her arms an I had Resident R 47's pants. Resident R47 was hanging on the side row and we put her into bed. Prior to that, Resident R47 was hanging on both side of her wheelchair with her arm down dangling over the metal part of the wheelchair. That when NA Employee E2 and I put her into bed she was going to fall out of the chair leaning on both side of the chair.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a witness statement dated 5/29/24, completed by NA Employee E2 stated, On Wednesday May 22, 2024 I worked the back section assignment on the third floor on the 3 p.m. to 11 p.m. shift. Resident R47 was not in my assignment however her NA for the night asked for assistance in changing her for last rounds before I had to go downstairs to assist another aide in last rounds because she was alone and had an admission come in. NA Employee E1 and I went into her [Resident R47] room, transferred her from her wheelchair by stand pivot to bed slowly, rolled her from side to side to clean her up for bed. NA Employee E1 finished up in Resident R47's room and I headed downstairs to the first floor.</p> <p>During an interview on 8/8/24, at 10:02 a.m. the Director of Nursing (DON) confirmed that the facility failed to obtain witness statements from Resident R47's roommate and the nurse assigned to Resident R47 on 5/22/24, during the 3 p.m. to 11 p.m. shift.</p> <p>During an interview on 8/8/24, at 10:02 a.m. the DON confirmed that the facility failed to conduct a thorough investigation to rule out neglect for one of two residents (Resident R47).</p> <p>28 Pa. Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.14 (c)(e) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (e)(1) Management.</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five of five residents sampled with facility-initiated transfers (Residents R6, R44, R51, R62, and R83).</p> <p>Findings include:</p> <p>Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE].</p> <p>Review of Resident R6's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/14/24, indicated diagnoses of high blood pressure, bipolar disorder (a mental condition marked by alternating periods of elation and depression), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time).</p> <p>Review of Resident 6's clinical record revealed that the resident was transferred to the hospital on 4/30/24, and returned to the facility on [DATE].</p> <p>Review of Resident R6's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of the clinical record indicated Resident R44 was admitted to the facility on [DATE].</p> <p>Review of Resident R44's MDS dated [DATE], indicated diagnoses of high blood pressure, ataxic gait (clumsy, staggering movements when walking), and heart failure (a progressive heart disease that affects pumping action of the heart muscles).</p> <p>Review of Resident R44's clinical record revealed that the resident was transferred to the hospital on 11/1/23, and returned to the facility on [DATE].</p> <p>Review of Resident R44's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of the clinical record indicated Resident R51 was admitted to the facility on [DATE].</p> <p>Review of Resident R51's MDS dated [DATE], indicated diagnoses of high blood pressure, septicemia (an infection that occurs when germs get into the bloodstream and spread), and muscle weakness.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record indicated Resident R51 was transferred to hospital on 7/15/24, and returned to the facility on [DATE].</p> <p>Review of Resident R51's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of the clinical record indicated Resident R62 was admitted to the facility on [DATE].</p> <p>Review of Resident R62's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time)</p> <p>Review of the clinical record indicated Resident R62 was transferred to hospital on 7/10/24, and returned to the facility on [DATE].</p> <p>Review of Resident R62's clinical record failed to reveal a physician ' s order to send Resident R62 to the hospital for evaluation and treatment.</p> <p>Review of Resident R62's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of the clinical record indicated Resident R83 was admitted to the facility on [DATE].</p> <p>Review of Resident R83's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and end stage renal disease (ESRD, an inability of the kidneys to filter the blood).</p> <p>Review of the clinical record indicated Resident R83 was transferred to hospital on 2/8/24, and returned to the facility on [DATE].</p> <p>Review of Resident R83's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>During an interview on 8/6/24, at 11:27 a.m. Registered Nurse (RN) Employee E14 stated, We typically send POLST (a form the specifies the level of care desired in a medical emergency), orders, face sheet, and labs if we have them. You won't find documentation in the medical record, that's something we usually don't chart.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Platinum Ridge Ctr for Rehab & Healing		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Broadview Boulevard Brackenridge, PA 15014	
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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/6/24, at 1:25 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five of five residents sampled with facility-initiated transfers (Residents R6, R44, R51, R62, and R83).</p> <p>28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for three of three residents (Residents R51, R62, and R83).</p> <p>Findings include:</p> <p>Review of facility policy Transfer or Discharge Notice dated 8/24/23, indicated a resident and/or his or her representative will be given a thirty-day advance notice of an impending transfer or discharge from our facility. Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge: an immediate transfer or discharge is required by the resident's urgent medical needs. A copy of these notices will be sent to the Office of the State Long-Term Care Ombudsman.</p> <p>Review of the clinical record indicated Resident R51 was admitted to the facility on [DATE].</p> <p>Review of Resident R51's MDS dated [DATE], indicated diagnoses of high blood pressure, septicemia (an infection that occurs when germs get into the bloodstream and spread), and muscle weakness.</p> <p>Review of the clinical record indicated Resident R51 was transferred to hospital on 7/15/24 and returned to the facility on [DATE].</p> <p>Review of Resident R51's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>Review of the clinical record indicated Resident R62 was admitted to the facility on [DATE].</p> <p>Review of Resident R62's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time)</p> <p>Review of the clinical record indicated Resident R62 was transferred to hospital on 7/10/24 and returned to the facility on [DATE].</p> <p>Review of Resident R62's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>Review of the clinical record indicated Resident R83 was admitted to the facility on [DATE].</p> <p>Review of Resident R83's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and end stage renal disease (ESRD, an inability of the kidneys to filter the blood).</p> <p>(continued on next page)</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record indicated Resident R83 was transferred to hospital on 2/8/24 and returned to the facility on [DATE].</p> <p>Review of Resident R83's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>During an interview on 8/6/24, at 1:25 p.m. the Nursing Home Administrator confirmed that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for three of three residents (Residents R51, R62, and R83).</p> <p>28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</b></p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization ) for five of five resident hospital transfers (Residents R6, R44, R51, R62, and R83).</p> <p>Findings include:</p> <p>Review of facility policy Bed-Holds and Returns dated 8/24/23, indicated prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy.</p> <p>Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE].</p> <p>Review of Resident R6's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/14/24, indicated diagnoses of high blood pressure, bipolar disorder (a mental condition marked by alternating periods of elation and depression), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time).</p> <p>Review of Resident 6's clinical record revealed that the resident was transferred to the hospital on 4/30/24, and returned to the facility on [DATE].</p> <p>Review of Resident R6's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 4/30/24.</p> <p>Review of the clinical record indicated Resident R44 was admitted to the facility on [DATE].</p> <p>Review of Resident R44's MDS dated [DATE], indicated diagnoses of high blood pressure, ataxic gait (clumsy, staggering movements when walking), and heart failure (a progressive heart disease that affects pumping action of the heart muscles).</p> <p>Review of Resident R44's clinical record revealed that the resident was transferred to the hospital on 11/1/23, and returned to the facility on [DATE].</p> <p>Review of Resident R44's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 11/1/23.</p> <p>Review of the clinical record indicated Resident R51 was admitted to the facility on [DATE].</p> <p>Review of Resident R51's MDS dated [DATE], indicated diagnoses of high blood pressure, septicemia (an infection that occurs when germs get into the bloodstream and spread), and muscle weakness.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record indicated Resident R51 was transferred to hospital on 7/15/24 and returned to the facility on [DATE].</p> <p>Review of Resident R51's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 7/15/24.</p> <p>Review of the clinical record indicated Resident R62 was admitted to the facility on [DATE].</p> <p>Review of Resident R62's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time)</p> <p>Review of the clinical record indicated Resident R62 was transferred to hospital on 7/10/24 and returned to the facility on [DATE].</p> <p>Review of Resident R62's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 7/10/24.</p> <p>Review of the clinical record indicated Resident R83 was admitted to the facility on [DATE].</p> <p>Review of Resident R83's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and end stage renal disease (ESRD, an inability of the kidneys to filter the blood).</p> <p>Review of the clinical record indicated Resident R83 was transferred to hospital on 2/8/24 and returned to the facility on [DATE].</p> <p>Review of Resident R83's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 2/8/24.</p> <p>During an interview on 8/6/24, at 11:29 a.m. Registered Nurse Employee E14 stated, We have the bed hold policy now, we didn't use to. We don't document that it was sent.</p> <p>During an interview on 8/6/24, at 1:25 p.m. the Nursing Home Administrator confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization ) for five of five resident hospital transfers (Residents R6, R44, R51, R62, and R83).</p> <p>28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</b></p> <p>Based on review of facility policy, resident interviews and observations, and staff interview it was determined that the facility failed to provide a beautician services for four of seven residents (Residents R6, R24, R32, and R61).</p> <p>Findings include:</p> <p>The facility Activities of Daily Living (ADLs), Supporting policy last reviewed 8/24/23, indicated residents will be provided with care, treatment, and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). It was indicated residents who are unable to carry out ADLs independently will be provided with the appropriate support and assistance with hygiene, including grooming.</p> <p>The facility Admission Packet dated 6/1/19, indicated the facility will provide a styling salon and a hairdresser if available on Thursdays.</p> <p>Review of admission record indicated Resident R32 was admitted to the facility on [DATE], with diagnoses of anxiety, depression, and muscle weakness.</p> <p>During an interview on 8/4/24, at 9:37 a.m. Resident R32 stated My hair needs cut so bad, that's why I'm wearing my hat. Resident R32 stated she has been without a haircut for about a year, and the facility does not have a beautician.</p> <p>During an interview on 8/4/24, at 12:20 p.m. Resident R32's family member indicated the facility's beautician was fired and it's been a while since Resident R32 had a haircut.</p> <p>During an resident council meeting on 8/5/24, at 1:03 p.m. 4 of 7 residents had a concern for the facility not having a beautician for several months.</p> <p>-Resident R6 was observed with a long beard and stated he needs assistance with cutting his beard and no one assists him since there is not a beautician.</p> <p>-Resident R24 stated she cannot recall the last time she seen a beautician and stated it's been a while.</p> <p>-Resident R32 stated she needs to see a beautician and that her hair is never this long.</p> <p>-Resident R61 was observed wearing a hat and stated he needed a haircut, it's been a long time.</p> <p>During an interview on 8/5/24, at 4:10 p.m. Nurse Aide, Employee E1 stated it's been awhile since the facility has been without beautician. NA, Employee E1 stated It's been so long, I can't recall.</p> <p>During an interview on 8/6/24, at 1:22 p.m. the Nursing Home Administrator confirmed the does not have a beautician and stated the facility is trying to find one. The NHA confirmed the facility failed to provide a beautician services for four of seven residents (Residents R6, R24, R32, and R61).</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 211.10(c)(d) Resident Care Policies</p> <p>28 Pa. Code 211.12 (d)(2) Nursing Services</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075</b></p> <p>Based on review of facility policy, clinical records, and staff interview it was determined that the facility failed to notify a physician of abnormal glucose readings via a Capillary Blood Glucose (CBG) level as per physicians order for two of four residents (Resident R62 and R83).</p> <p>Findings include:</p> <p>The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours), or a blood glucose greater than 180 mg/dL one to two hours after eating.</p> <p>Review of the facility's policy Obtaining a Fingerstick Glucose Level dated 8/24/24, indicated the purpose of this procedure is to obtain a blood sample to determine the resident ' s blood glucose level. Document the blood sugar results and if physician intervention is needed to adjust insulin or oral medication dosages. Report results promptly to the supervisor and the attending Physician.</p> <p>A review of the admission record indicated Resident R62 was admitted [DATE].</p> <p>Review of Resident R62's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 6/20/24, indicated that she was admitted with diagnoses that included diabetes mellitus (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), high blood pressure, and depression.</p> <p>Review of Resident R62's current care plan on 10/24/23, indicated to perform fasting blood sugars as ordered by doctor.</p> <p>Review of Resident R62's physician order dated 7/24/24, indicated to administer insulin subcutaneously per sliding scale (varies the dose of insulin based on blood glucose level) and notify the physician if the blood sugar results are greater than 401mg/dl.</p> <p>Review of Resident R62's Blood Glucose records from November 2023 to April 2024, indicated the following blood glucose measurements:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11/27/23 - 425 mg/dl</p> <p>12/27/23 - 471 mg/dl</p> <p>1/22/24 - 429 mg/dl</p> <p>2/13/24 - 451 mg/dl</p> <p>2/15/24 - 460 mg/dl</p> <p>4/3/24 - 439 mg/dl</p> <p>4/13/24 - 488 mg/dl</p> <p>Review of Resident R62's clinical progress notes did not include physician notifications for the abnormal blood glucose levels for 11/27/23, 12/27/23, 1/22/24, 2/13/24, 2/15/24, 4/3/24, and 4/13/24.</p> <p>During an interview on 8/5/24, at 2:15 p.m. Licensed Practical Nurse (LPN) Employee E18 confirmed that the physician should have been notified with blood glucose levels above 401 mg/dl per physician order and there is no documentation of the physician being notified of Resident R62's elevated blood glucose levels on 11/27/23, 12/27/23, 1/22/24, 2/13/24, 2/15/24, 4/3/24, and 4/13/24.</p> <p>Review of admission record indicated Resident R83 was admitted to the facility on [DATE].</p> <p>Review of MDS dated [DATE], indicated the diagnoses of end stage renal disease (ESRD, an inability of the kidneys to filter the blood), high blood pressure, and diabetes mellitus.</p> <p>Review of Resident R83's current care plan on 10/24/23, indicated to monitor, document and report signs of hyperglycemia.</p> <p>Review of Resident R83's physician order dated 6/3/24, indicated to administer insulin subcutaneously per sliding scale and notify the physician if the blood sugar results are greater than 401mg/dl.</p> <p>Review of Resident R83's Blood Glucose records from June 2024, indicated the following blood glucose measurements:</p> <p>6/14/24 - 436mg/dl</p> <p>Review of Resident R83's clinical progress notes did not include physician notifications for the abnormal blood glucose level for 6/14/24.</p> <p>During an interview on 8/5/24, at 2:15 p.m. LPN Employee E15 indicated that the physician should have been notified with blood glucose levels above 401 mg/dl. per physician order and there is no documentation of the physician being notified of Resident R83's elevated blood glucose level on 6/14/24.</p> <p>During an interview on 8/6/24, at 3:01 p.m., Director of Nursing confirmed that the facility failed to notify a physician of abnormal glucose readings via a Capillary Blood Glucose (CBG) level as per physicians order for two of four residents (Resident R62 and R83).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 201.18 (b)(1) Management.</p> <p>28 Pa. Code 201.29(a) Resident Rights</p> <p>28 Pa. Code 211.10 (c)(d) Resident Care policies</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on review of facility policy, clinical record review, observations, and staff interview, it was determined that the facility failed to provide prescribed pressure ulcer treatment and services consistent with professional standards of practice for two of two residents (Residents R7 and R29).</p> <p>Findings include:</p> <p>Review of facility policy Pressure Ulcers/Skin Breakdown-Clinical Protocol last reviewed 8/24/23, indicated the physician will order pertinent wound treatments, and guide the care plan as appropriate.</p> <p>Review of facility policy Care Plans, Comprehensive Person-Centered last reviewed 8/24/23, indicated it is the facility policy to develop and implement a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident 's physical, psychosocial and functional needs for each resident.</p> <p>Review of facility policy Wound Care dated 8/23/23, indicated the following information should be recorded in the resident's medical record: the type of wound care given, the date and time the wound care was given, the name and title of the individual performing the wound care, if the resident refused the treatment and the reason(s) why, and the signature and title of the person recording the data.</p> <p>Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE].</p> <p>Review of Resident R7's Minimum Data Set (MDs - a periodic assessment of care needs) dated 5/2/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and depression (a constant feeling of sadness and loss of interests).</p> <p>Review of a physician order dated 7/9/21 indicated to complete weekly visual skin checks every day shift every Wednesday.</p> <p>Review of Resident R7's clinical record May 2024 through July 2024 revealed a Weekly Skin Observation V1 report was completed on the following dates:</p> <p>5/8/24</p> <p>6/26/24</p> <p>7/10/24</p> <p>8/1/24</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R7's clinical record May 2024 through July 2024 failed to reveal completed Weekly Skin Observation V1 reports for 10 out of 14 weeks (5/1/24, 5/15/24, 5/22/24, 5/29/24, 6/5/24, 6/12/24, 6/19/24, 7/3/24, 7/17/24, and 7/24/24).</p> <p>During an interview on 8/8/24, at 9:01 a.m. Infection Preventionist Employee E7 stated the weekly skin assessments are to be completed on the computer and that the facility does not utilize paper charting for weekly skin assessments.</p> <p>During an interview on 8/8/24, at 9:41 a.m. Infection Preventionist Employee E7 confirmed that the facility failed to complete weekly skin assessments as ordered for Resident R7.</p> <p>Review of a physician order dated 5/29/24, for Resident R7 indicated to cleanse right buttocks with soap and water, apply thin layer of dermaseptin (cream that prevents irritation from moisture and promotes healing) every shift as needed to maintain skin integrity.</p> <p>Review of Resident R7's June 2024 Treatment Administrator Record (TAR) revealed the treatment was not documented as completed during the 3 p.m. to 11 p.m. shift on 6/3/24, 6/4/24, 6/5/24, 6/6/24, 6/10/24, 6/11/24, 6/12/24, 6/13/24, 6/14/24, 6/17/24, 6/18/24, 6/19/24, 6/21/24, 6/24/24, 6/25/24, 6/26/24, 6/27/24, and 6/28/24.</p> <p>Review of Resident R7's July 2024 TAR revealed the treatment was not documented as completed during the 3 p.m. to 11 p.m. shift on 7/1/24, 7/2/24, 7/3/24, 7/4/24, 7/5/24, 7/8/24, 7/9/24, 7/10/24, 7/11/24, 7/12/24, 7/15/24, 7/16/24, 7/17/24, 7/18/24, 7/22/24, 7/23/24, 7/24/24, 7/25/24, 7/26/24, 7/29/24, 7/30/24, and 7/31/24.</p> <p>Review of Resident R7's August 2024 TAR revealed the treatment was not documented as completed during the 3 p.m. to 11 p.m. shift on 8/1/24, 8/2/24, 8/6/24, and 8/7/24. Review of Resident R7's August 2024 TAR revealed the treatment was not documented as completed during the 11 p.m. the 7 a.m. shift on 8/2/24.</p> <p>During an interview on 8/8/24, at 9:51 a.m. Infection Preventionist Employee E7 confirmed the treatment was not documented as completed on the dates listed above for Resident R7.</p> <p>Review of Resident R29's clinical record indicated the resident was admitted [DATE], with diagnoses of quadriplegia (paralysis that affects all limbs and body from the neck down), anxiety, and depression.</p> <p>Review of Resident R29's care plan dated 8/9/23, indicated the resident has the potential for pressure ulcer development due to immobility. Interventions indicated to apply soft heel boots at all times beside from ambulation.</p> <p>Review of Resident R29's Minimum Data Set (MDS- a periodic assessment of resident care needs) dated 5/6/24, indicated the resident's diagnoses were current. Section M Skin Conditions M0300 indicated the resident had one stage 3 pressure ulcer (full thickness skin loss that may extend into the subcutaneous (under the skin) tissue layer).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R29's care plan dated 5/7/24, indicated the resident had actual skin breakdown related to pressure injury of left distal index finger. Interventions included to administer treatment per physician orders.</p> <p>Review of Resident R29's physician order dated 7/3/24, indicated to cleanse the second finger to left hand with normal saline solution (solution used to clean wounds), pat dry, apply Medihoney (type of wound gel that has antibacterial and bacterial resistant properties), and cover with a small border gauze dressing once a day in the evening shift for wound care and as needed.</p> <p>Review of Resident R29's progress note dated 7/30/24, indicated the resident had a Stage 3 left distal index finger pressure injury measuring 0.5 centimeters (cm) x 0.5 cm x 0.1 cm.</p> <p>Review of Resident R29's Braden Scale assessment dated [DATE], indicated Resident R29 was at moderate risk (score of 14) for pressure ulcer development (a standardized, evidence-based assessment tool commonly used in health care to assess and document a client 's risk for developing pressure injuries).</p> <p>During an observation 8/5/24, at 10:09 a.m. Resident R29's wound dressing to her left index finger was dated 8/2/24. Resident R29 was observed not wearing soft heel boots as her care plan indicated.</p> <p>During an interview on 8/5/24, at 10:10 a.m. Licensed Practical Nurse (LPN), Employee E17 confirmed Resident R29's dressing was dated 8/2/24, and the resident did not have soft heel boots on. LPN, Employee E17 confirmed the facility failed to complete the resident's dressing as ordered and implement pressure ulcer care interventions.</p> <p>Review of Resident R29's August 2024 Treatment Administrator Record (TAR) failed to include Resident R29's wound care order for the resident's index finger.</p> <p>During an interview on 8/5/24, at 10:18 a.m. Registered Nurse Supervisor, Employee E16 stated treatment orders are documented in the TAR, and the physician order indicates how often the dressing must be completed. If the dressing is not signed off for completion in the TAR, then a progress note must be entered indicating the reason the dressing was not completed, then a supervisor must be notified,</p> <p>During an interview on 8/5/24, at 10:22 a.m. the Director of Nursing confirmed that the facility failed to provide pressure ulcer treatment consistent with professional standards of practice for one of two residents (Resident R29).</p> <p>During an interview on 8/7/24, at 11:38 a.m. LPN, Employee E7 confirmed Resident R29's order was not transcribe to be signed off in the TAR.</p> <p>28 Pa. Code:211.10(a)(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</b></p> <p>Based on review of facility policy, clinical records, facility investigation, and resident and staff interviews, it was determined that the facility failed to provide adequate supervision, assistance, and proper equipment to prevent injuries during a transfer for one of four residents reviewed (Resident R47). This failure resulted in Resident R47 having pain, bruising, and was transferred to the hospital and diagnosed with a fractured rib, which were sustained during an improper transfer. The facility failed to maintain resident Kardexes (a snapshot of resident care needs) and care plans to reflect accurate mobility transfer statuses. This failure created an Immediate Jeopardy situation for nine of 17 residents reviewed (Residents R47, R7, R21, R29, R33, R37, R51, R68, and R75).</p> <p>Findings include:</p> <p>Review of facility policy Accidents and Incidents - Investigating and Reporting dated 8/24/23, indicated all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.</p> <p>Review of facility policy Activities of Daily Living (ADLs), Supporting dated 8/24/23, indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene, mobility, elimination, dining, and communication.</p> <p>Review of facility policy Safe Lifting and Movement of Residents dated 8/24/23, indicated in order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Manual lifting of residents shall be eliminated when feasible.</p> <p>Review of the clinical record indicated Resident R47 was admitted to the facility on [DATE].</p> <p>Review of Resident R47's MDS dated [DATE], indicated diagnoses of high blood pressure, atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), and anemia (too little iron in the body causing fatigue). Section C0200 Brief Interview for Mental Status (BIMS) revealed Resident R47 scored a 15 indicating cognitively intact.</p> <p>Review of Resident R47's physician orders dated 5/21/24, indicated the resident transferred with an assist x 2, no ambulation. This order was discontinued on 6/4/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Facility Submitted documentation dated 5/24/24, stated, On 5/24/24 at 6:45 a.m., the Licensed Practical Nurse (LPN) on duty was called into Resident R47's room by the Nurse Aide (NA). NA reported some bruising on residents right and left breast and left abdominal areas, both lower and upper. When the LPN asked the resident what happened, she stated the following. NA Employee E1 and another large girl (NA Employee E2) were taking her out of the chair and transferring her to the bed when they grabbed both armpits and pulled her up. She then stated, Please stop you're hurting my arms! Resident stated both NAs said, You're almost to bed, you're fine. Resident stated that areas are painful. Resident was assessed by the Registered Nurse (RN) Supervisor. Upon assessment a 23 centimeter (cm) L (length) x 5 cm W (width) dark purple in color bruise is observed to her left lower breast area. The skin is intact, no swelling or redness present. Resident's right lower breast area observed with a 16 cm L x 6 cm W dark purple in color bruise. No swelling or redness present. Also a 9 cm L x 2 cm W red and purple in color bruise is present to the resident's right upper outer abdominal area and a 7 cm L x 1 cm W red and purple in color bruise is present directly below the first abdominal bruise. Current transfer order: Transfer with assist x 2, no ambulation. Resident was wearing proper footwear. Update: Resident was sent to the emergency department on 5/28/24. A CT (a computed tomography scan) of the chest was done with results showing a possible acute anterior (nearer the front) 3rd rib fracture in addition to multiple old right sided rib fractures.</p> <p>Review of a Nurse Practitioner (NP) Note dated 5/24/24, completed by NP Employee E11, stated, Patient seen for new onset chest bruising per request of nursing. She [Resident R47] reports that the evening prior to my assessment she was assisted back to bed with assistance. She was feeling very weak and needed the staff to help lift her up by her arms, which she thinks caused the bruising. Patient states the areas were tender but currently she has no pain.</p> <p>Review of a Skin/Wound Follow-Up Note dated 5/24/24, at 7:45 a.m. completed by RN Employee E10 stated, Resident was assessed by this writer this morning when charge nurse reported this resident had bruises to both of her breasts. On assessment a 23 cm L x 5 cm W dark purple in color bruise is observed to her left lower breast area. The skin is intact, No swelling or redness is present. Resident's right lower breast area is observed with a 16 cm L x 6 cm W dark purple in color bruise. No swelling or redness is present. Also a 9.0 cm L x 2 cm W red and purple in color bruise is present to resident's right upper outer abdominal area and a 7.0 cm L x 1.0 cm W red and purple in color bruise is present directly below the first abdominal bruise. Resident states areas are painful. Resident receives Eliquis (a medication administered to prevent blood clots) 2.5 milligrams BID (twice a day). Therapy to be consulted to evaluate transfer. Resident educated to inform staff when any situation occurs for resident's safety. Resident stated, I didn't tell my parents. I don't want trouble. Staff to monitor bruising and report any changes to MD (physician). MD notified by fax. Family to be notified this morning.</p> <p>Review of a Skin/Wound Note dated 5/24/24, at 6:46 a.m. completed by LPN Employee E9 stated, Was called in to residents room by NA. NA reports some bruising on residents right and left breast and left abdominal areas, both lower and upper. When asked resident what happened she stated the following, NA Employee E1 and another large girl [NA Employee E2] were taking her out of the chair and transferring her to the bed when they grabbed both armpits and pulled her up. She then stated, Please stop you're hurting breaking my arms! Resident stated both NAs said, You're almost to the bed, you're fine.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of a Nursing Progress Note dated 5/28/24, at 11:03 a.m. completed by RN Employee E14 stated, Resident seen by CRNP (Certified Registered Nurse Practitioner), ordered to send to ER (emergency room) for possible bilateral (both sides) lower extremity infection. 911 called to transport. Report given. Daughter aware and going to emergency room .</p> <p>Review of a Hospitalist History &amp; Physical dated 5/28/24, completed by a Physician Assistant at the emergency department stated, Closed fracture of one rib of right side. CT of the chest abdomen and pelvis reveals possibly acute right anterior 3rd rib fracture in addition to multiple old right-sided rib fractures. Suspect secondary to trauma from being lifted by staff member at SNF (skilled nursing facility). Traumatic ecchymosis (bruising) of chest: patient noted to have ecchymosis to chest wall, bilateral breasts, upper abdomen, and bilateral flanks and has some tenderness to lower chest and bilateral rib cage. Ecchymosis is secondary to trauma from being manually lifted by staff at SNF to transfer patient from her wheelchair into bed. She states that she was experiencing pain while being lifted.</p> <p>Review of a witness statement dated 5/27/24, completed by NA Employee E1 stated, Resident R47 was complaining on Monday evening that the side of her breasts were hurting. I said you're leaning on the side of your wheelchair, so another NA and I help her into bed. When I helped Resident R47 put her gown on she had no bruising. The next time I was here was Wednesday. I had to get Resident R47's weight. I was helping Physical Therapy transfer Resident R47 into the wheelchair. She said before you put me into the chair, I'm very sore on my upper body. That night, NA Employee E2 and I put Resident R47 to bed. NA Employee E2 had her upper half under her arms and I had Resident R47's pants. Resident R47 was hanging on the side row and we put her into bed. Prior to that, Resident R47 was hanging on both side of her wheelchair with her arm down dangling over the metal part of the wheelchair. That when NA Employee E2 and I put her into bed she was going to fall out of the chair leaning on both side of the chair.</p> <p>Review of a witness statement dated 5/29/24, completed by NA Employee E2 stated, On Wednesday May 22, 2024 I worked the back section assignment on the third floor on the 3 p.m. to 11 p.m. shift. Resident R47 was not in my assignment however her NA for the night asked for assistance in changing her for last rounds before I had to go downstairs to assist another aide in last rounds because she was alone and had an admission come in. NA Employee E1 and I went into her [Resident R47] room, transferred her from her wheelchair by stand pivot to bed slowly, rolled her from side to side to clean her up for bed. NA Employee E1 finished up in Resident R47's room and I headed downstairs to the first floor.</p> <p>During an interview on 8/5/24, at 10:07 a.m. LPN Employee E3 stated, Resident transfer status is in the computer, the aides have it in their Kardex.</p> <p>During an interview on 8/5/24, at 10:13 a.m. NA Employee E4 stated, The transfer status is found in their chart, it's on our kiosk charting. If I saw a mobility status for assist x 2 no ambulation, I would say that means a hooyer with two people.</p> <p>During an interview on 8/5/24, at 10:17 a.m. NA Employee E1 stated, The transfer status is in the kiosk in the Kardex. I'm not sure what assist x 2 no ambulation means, it's a very confusing order. I always grab a second person, but it is very confusing. I don't know what it means.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/5/24, at 10:37 a.m. NA Employee E5 stated, The transfer status is in the computer, that's the only place. Assist x 2 no ambulation means two people to help transfer, I think it's with a lift.</p> <p>During an interview on 8/5/24, at 12:36 p.m. NA Employee E1 stated, On Monday morning she [Resident R47] was complaining under her breast near ribs it was hurting, she had therapy that day. I was just helping therapy transfer her and she was complaining of pain. I told one nurse and therapy knew. Resident R47 was also saying someone transferred her in bed on Tuesday. Wednesday night I asked NA Employee E2 can you please help me transfer her into bed. Before that she was just two assist, under arm then by pant leg. I put my foot in between to pivot. Each of us held on to her pants and both on each side, hooked our arms under her arm pits.</p> <p>During an interview on 8/5/24, at 1:23 p.m. the Director of Nursing (DON) stated, The transfer orders are in the Kardex. The aides can also ask the nurse, I do not think the transfer status would be anywhere else besides the Kardex.</p> <p>Review of Resident R47's physician orders dated 6/5/24, stated, Transfers total assist x 2 via hooyer (a mechanical lift designed to assist caregivers in safely transferring individuals with limited mobility), no ambulation.</p> <p>Review of Resident R47's clinical record on 8/5/24, revealed that the resident's transfer status was listed as the resident is able to transfer with assist x 1, may ambulate to/from bathroom with wheeled walker assist x 1 in both her care plan and Kardex.</p> <p>Additional clinical record reviews of Residents R7, R21, R29, R33, R37, R51, R68, and R75 revealed the following concerns:</p> <p>Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE].</p> <p>Review of Resident R7's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and depression (a constant feeling of sadness and loss of interests).</p> <p>Review of a physician order dated 2/9/22 indicated resident transfers total assist x 2 via hooyer lift, no ambulation.</p> <p>Review of Resident R7's clinical record on 8/5/24, revealed that the transfer order was not included in her Kardex.</p> <p>Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE].</p> <p>Review of Resident R21's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia, and anxiety (a feeling of worry, nervousness, or unease).</p> <p>Review of a physician order dated 3/27/24 indicated resident transfers assist x 2, no ambulation.</p> <p>Review of Resident R21's clinical record on 8/5/24, revealed that the transfer order was not included in her care plan or in her Kardex.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record indicated Resident R29 was admitted to the facility on [DATE].</p> <p>Review of Resident R29's MDS dated [DATE], indicated diagnoses of hyperlipidemia (high levels of fats in the blood), aphasia (language disorder that affects communication), and quadriplegia (paralysis of all four limbs).</p> <p>Review of a physician order dated 11/29/23, indicated the resident transfers with full body hooyer lift, assist x 2.</p> <p>Review of Resident R29's clinical record on 8/5/24, revealed that the transfer status was listed as full body hooyer lift x 2, walk in corridor and walk in room.</p> <p>Review of the clinical record revealed that Resident R33 was admitted to the facility on [DATE].</p> <p>Review of Resident 33's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia, and stroke.</p> <p>Review of the clinical record indicated Resident R33 had a physician's order dated 7/11/24, that stated, patient transfers assist x 1, no ambulation.</p> <p>Review of Resident R33's clinical record on 8/5/24, revealed that the transfer order was not included in her care plan or in her Kardex.</p> <p>Review of the clinical record indicated Resident R37 was admitted to the facility on [DATE].</p> <p>Review of Resident R37's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle weakness, and hyperlipidemia.</p> <p>Review of a physician order dated 4/9/24, indicated the resident transfers total assist x 2 via hooyer, no ambulation.</p> <p>Review of Resident R37's clinical record on 8/5/24, revealed that the transfer order was not included in her care plan or in her Kardex.</p> <p>Review of the clinical record indicated Resident R51 was admitted to the facility on [DATE].</p> <p>Review of Resident R51's MDS dated [DATE], indicated diagnoses of high blood pressure, septicemia (an infection that occurs when germs get into the bloodstream and spread), and muscle weakness.</p> <p>Review of a physician order dated 7/24/24, indicated the resident transfers with extensive assist x 1, no ambulation.</p> <p>Review of Resident R51's clinical record on 8/5/24, revealed that the transfer order was not included in her care plan or in her Kardex.</p> <p>Review of the clinical record revealed that Resident R68 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident 68's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (too much sugar in the blood), and weakness.</p> <p>Review of clinical record indicated Resident R68 had a physician's order dated 10/24/22, that stated, Transfer with a total lift with assist x 2.</p> <p>Review of Resident R68's clinical record on 8/5/24, revealed that the transfer order was not included in her care plan or in her Kardex.</p> <p>Review of the clinical record indicated Resident R75 was admitted to the facility on [DATE].</p> <p>Review of Resident R75's MDS dated [DATE], indicated diagnoses of anemia, high blood pressure, and hyperlipidemia.</p> <p>Review of a physician order dated 11/15/23, indicated the resident transfers with extensive assist x 1 with wheeled walker, may ambulate up to 50 feet with right platform wheeled walker assist x 1 and wheelchair follow.</p> <p>Review of Resident R75's clinical record on 8/5/24, revealed that the transfer order was not included in his care plan or in his Kardex.</p> <p>During an interview on 8/5/24, at 1:38 p.m. the DON was made aware than an Immediate Jeopardy (IJ) existed. The Nursing Home Administrator (NHA) was provided the IJ Template and at that time a corrective action plan was requested.</p> <p>During an interview on 8/5/24, at 1:49 p.m. the Director of Rehab Employee E6 stated, Resident R47's transfer order was entered incorrectly when the incident occurred on 5/22/24. It should have said assist x 2 or hoier lift. Assist x 2 could mean a stand-pivot transfer with max assistance.</p> <p>On 8/5/24, at 5:30 p.m. an acceptable Corrective Action Plan was received, which included the following interventions:</p> <ul style="list-style-type: none"> <li>- Resident R47's transfer status will be verified with therapy and care plan and Kardex will be updated by the facility Director of Rehabilitation by 8/5/24.</li> <li>- All resident transfer statues and physician orders will be reviewed for accuracy and updated as needed by facility Director of Rehabilitation as of 8/5/24.</li> <li>- All resident's physician ordered transfer status will be reviewed for accuracy and updated as needed on the resident's care plan by the facility assessment office and Director of Rehabilitation by 8/5/24.</li> <li>- All resident physician ordered transfer status and corresponding resident's Kardex will be reviewed for accuracy by the facility assessment office and Director of Rehabilitation by 8/5/24.</li> <li>- The Safe Lifting and Resident Movement policy has been reviewed on 8/5/24 by the facility Administrator and Director of Nursing and accepted as written.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>- Education on the Safe Lifting and Resident Movement policy as well as finding the transfer orders and how to have the transfer orders properly reflected on the Kardex will be provided to facility rehabilitation and nursing staff, by the Director of Nursing, or designee(s) starting on 8/5/24 and will be completed by 8/6/24. All remaining nursing staff shall complete the education prior to duty.</p> <p>- Audits will be completed daily by the Director of Nursing, or designee, five days a week for eight weeks. The results of the audits will be communicated to the Quality Assurance and Performance Improvement Committee as needed.</p> <p>Review of medical records on 8/6/24, indicated that all 86 residents had physician transfer orders reviewed and updated for accuracy, and that all resident care plans and Kardexes had been updated to reflect current physician transfer orders.</p> <p>Review of facility documents on 8/6/24, revealed that the facility is auditing all resident transfer statuses and orders.</p> <p>Review of facility documents on 8/6/24, revealed that the facility had 107 nursing and rehabilitation employees and that 100% had received resident transfer status education. 36 of these employees received formal education on the Safe Lifting and Resident Movement policy and how to properly enter resident transfer orders and have the orders reflect in the Kardex and care plan. 71 of these employees had received this education via telephone as they had not been working in the building. One employee received this education via e-mail. Staff are to sign that they received this education when they are in the building before the start of their next shift.</p> <p>During staff interviews conducted on 8/6/24, between 9:45 a.m. and 11:15 a.m. 22 nursing and rehabilitation employees confirmed that they received education on how to enter and locate resident transfer orders and the Safe Lifting and Resident Movement policy. 12 of these employees had received education in person and 10 of these employees had received education over the telephone and signed the training sheet prior to the start of their shift.</p> <p>The Immediate Jeopardy was lifted on 8/6/24, at 12:39 p.m. when the action plan implementation was verified.</p> <p>During an interview on 8/6/24, at 1:22 p.m. the NHA confirmed that the facility failed to provide adequate supervision, assistance, and proper equipment to prevent injuries during a transfer, which resulted in Resident R47 having pain and bruising. While at the hospital for an evaluation of a lower extremity infection, Resident R47 was diagnosed with a fractured rib, which was sustained during the improper transfer. During this interview, the NHA confirmed that the facility failed to maintain resident Kardexes and care plans to reflect accurate mobility transfer statuses and that this failure created an Immediate Jeopardy situation for nine of 17 residents reviewed.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(e)(1) Management.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50075</p> <p>Based on facility policy review, observation, clinical record review, and staff interviews, it was determined that the facility failed to monitor colostomy site and services consistent with professional standards of practice and failed to implement the colostomy care plan for one of three residents reviewed (Resident R65).</p> <p>Findings include:</p> <p>Review of facility policy Colostomy and Ileostomy Care dated 8/24/23, indicated the purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident ' s skin to fecal matter. Notify the supervisor of any abnormal findings. When evaluating the condition of the residents ' skin, note the following:</p> <ul style="list-style-type: none"> <li>- Breaks in the skin</li> <li>- Redness</li> <li>- Signs of infection (heat, swelling, pain, redness, and drainage)</li> </ul> <p>Review of facility policy Care Plans, Comprehensive Person-Centered last reviewed 8/24/23, indicated it is the facility policy to develop and implement a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs for each resident.</p> <p>Review of the admission record indicated Resident R65 was admitted to the facility on [DATE].</p> <p>Review of Resident R65's MDS (MDS - a periodic assessment of care needs) dated 7/1/24, indicated the diagnoses of high blood pressure, end stage renal disease (ESRD, an inability of the kidneys to filter the blood), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Section H indicated a colostomy (a surgical process that diverts bowel through an artificial opening in the abdomen wall) was present.</p> <p>During an observation of Resident R65 on 8/4/24, at 9:45 a.m. indicated she had a colostomy.</p> <p>Review of Resident R65's care plan dated 6/26/24, indicated to monitor stoma site for any s/s of infection such as redness, tenderness, drainage, fever, and pain.</p> <p>Review of Resident R65's current physician orders failed to indicate to monitor the stoma (opening of the colostomy) for signs of infection, drainage, or appearance of stoma.</p> <p>During an interview on 8/6/24, at 11:15 a.m. Licensed Practical Nurse Employee E15 stated I don ' t see an order from the doctor for that and stated there should be.</p> <p>(continued on next page)</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/6/24, at 2:59 p.m. the Director of Nursing confirmed the facility failed to monitor colostomy site and services consistent with professional standards of practice and failed to implement the colostomy care plan for one of three residents reviewed (Resident R65).</p> <p>28 Pa. Code: 211.11 (a)(c)(d) Resident care plan</p> <p>28 Pa. Code: 211.10(c) Resident care policies.</p> <p>28 Pa. Code:211.12(d)(1) Nursing services.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</b></p> <p>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 four of four residents (Residents R7, R21, R37, and R79).</p> <p>Findings include:</p> <p>Review of facility policy Proper Use of Side Rails dated 8/24/23, indicated an assessment will be made to determine if the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's bed mobility, ability to change positions, risk of entrapment from the use of side rails, and that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE].</p> <p>Review of Resident R7's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/2/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and depression (a constant feeling of sadness and loss of interests).</p> <p>Review of a physician order dated 8/22/20 indicated the usage of quarter side rails on each side of bed to promote mobility/independence.</p> <p>Review of Resident R7's care plan on 8/5/24, at 2:34 p.m. indicated bilateral (both sides) quarter rails to promote independence and bed mobility.</p> <p>Review of Resident R7's clinical record on 8/5/24, at 2:34 p.m. failed to reveal an ongoing assessment for side rail usage.</p> <p>An observation on 8/4/24, at 9:50 a.m. revealed side rails on both sides of Resident R7's bed.</p> <p>Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE].</p> <p>Review of Resident R21's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and anxiety (a feeling of worry, nervousness, or unease).</p> <p>Review of a physician order dated 9/20/23 indicated quarter side rails up while in bed to promote independence.</p> <p>Review of Resident R21's care plan on 8/5/24, at 2:30 p.m. indicated bilateral quarter bedrails to promote independence and bed mobility.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R21's clinical record on 8/5/24, at 2:30 p.m. failed to reveal an ongoing assessment for side rail usage.</p> <p>An observation on 8/4/24, at 9:25 a.m. revealed side rails on both sides of Resident R21's bed.</p> <p>Review of the clinical record indicated Resident R37 was admitted to the facility 12/6/23.</p> <p>Review of Resident R37's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle weakness, and hyperlipidemia (high levels of fats in the blood).</p> <p>Review of a physician order dated 1/5/24, indicated the usage of quarter side rails to promote independence and bed mobility.</p> <p>Review of Resident R37's care plan on 8/5/24, at 2:25 p.m. indicated quarter bilateral side rails to promote independence and mobility.</p> <p>Review of Resident R37's clinical record on 8/5/24, at 2:25 p.m. failed to reveal an ongoing assessment for side rail usage.</p> <p>An observation on 8/4/24, at 9:35 a.m. revealed side rails on both sides of Resident R37's bed.</p> <p>Review of the clinical record indicated Resident R79 was admitted to the facility on [DATE].</p> <p>Review of Resident R79's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia, and Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking).</p> <p>Review of Resident R79's Side Rail/Grab Bar Review dated 3/21/24, indicated bilateral quarter rails are indicated and serve as an enabler to promote independence .</p> <p>An observation on 8/4/24, at 10:27 a.m. revealed side rails on both sides of Resident R79's bed.</p> <p>Review of Resident R79's clinical record on 8/5/24, at 2:38 p.m. failed to reveal an ongoing assessment for side rail usage, an order for bed rails, or a care plan for usage of bed rails.</p> <p>During an interview on 8/6/24, at 2:20 p.m. infection Preventionist Employee E7 stated that side rail assessments should be completed on admission, quarterly, an annually.</p> <p>During an interview on 8/6/24, at 2:25 p.m. Infection Preventionist Employee E7 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 four of four residents (Residents R7, R21, R37, and R79).</p> <p>28 Pa. Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 211.12 (d) (1)(3)(5) Nursing services.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>46337</p> <p>Based on resident interviews, staff interviews, resident council minutes, and grievance review, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of four of eight residents (Resident R11, R28, R32, and R69).</p> <p>Findings Include:</p> <p>Review of the facility's PBJ Staffing Data Report Quarter 4 2023 (July 1 - September 30) indicted the facility was triggered for one star staffing rating and excessively low weekend staffing.</p> <p>Review of the facility's PBJ Staffing Data Report Quarter 2 2024 (January 1 - March 31) indicted the facility was triggered for one star staffing rating and excessively low weekend staffing.</p> <p>Review of the facility's Resident Council Minutes dated 3/5/24, indicated a resident had a concern that the aides do not answer the call bells. It was indicated it can take 20 minutes for staff to answer a call light.</p> <p>Review of the facility's Resident Council Minutes dated 4/2/24, indicated residents had a concern for aides taking too long to answer call lights.</p> <p>Review of the facility's Resident Council Minutes dated 5/7/24, indicated residents had a concern for aides taking too long to answer call lights. It was indicated the facility does not have enough staff on the weekends.</p> <p>Review of the facility's Resident Council Minutes dated 6/4/24, indicated the facility does not have enough staff on the weekends. It stated a resident had to wait three hours to get two wash cloths. It was also indicated staff are cutting up towels into wash cloths. It was stated the facility is lacking linen, especially on the weekends.</p> <p>Review of the facility's Resident Council Minutes dated 7/2/24, indicated the facility is lacking linen, especially on the weekends. It was indicated there are absolutely no linen on the floor and residents are laying on towels and bare mattresses.</p> <p>Review of the facility provided document dated 7/9/24, indicated a message was sent to staff on 7/8/24, that stated a lot of linen I being needlessly thrown away causing shortages.</p> <p>During an interview on 8/4/24, at 9:30 a.m. Resident R28 indicated there is usually only one aide for the whole floor, which results in longer wait times. Resident R28 indicated the facility is short on linen.</p> <p>During an interview on 8/4/24, at 9:37 a.m. Resident R32 stated the facility is always short staffed, we need more help here. Resident R32 indicated on days there is only one nurse and one nurse aide she can wait up to an hour to be changed.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 8/4/24, at 9:51 a.m. Nurse Aide, Employee E1 stated staffing is a really big issue here. NA, Employee E1 stated it can be difficult to pass trays timely and assist residents during meal times.</p> <p>During an interview on 8/4/24, at 10:04 a.m. NA, Employee E26 stated the facility does not have enough staff. NA, Employee E26 stated staff often call off on the weekends, which makes it difficult to complete morning care. NA, Employee E26 stated morning care for residents sometimes does not get completed until 3:00 p.m.</p> <p>During an interview on 8/4/24, at 12:20 p.m. Resident R32's family member stated she has to be here a lot. Staff often put trays in front of residents without helping them, then take them away without asking if you are finished and residents don't get fed. Resident R32's family member stated the facility is always short staffed.</p> <p>During a group interview on 8/5/24, at 1:03 p.m. the following was stated:</p> <p>7 out of 7 residents stated that there is not enough staff</p> <p>7 of 7 residents stated it can take 30 to 45 minutes for their call bell to be answered.</p> <p>4 of 7 residents stated no matter how many times you hit the button, staff walk pass without helping.</p> <p>During an interview on 8/6/24, at 10:08 a.m. NA, Employee E4 stated staffing has been an ongoing issue. NA, Employee E4 stated the floor does not have enough linen and it's difficult complete morning care.</p> <p>During an interview on 8/6/24, at 10:15 a.m. NA, Employee E23 was observed tearful and stated last night there was only one aide on the floor and this morning there was no linen. NA, Employee E23 stated if there is no linen, we run behind, we cannot give a shower if there is no linen. NA, Employee E23 indicated Resident R11 and Resident R69 had to be washed up this morning and dried with wash cloths.</p> <p>During an interview on 8/8/24, at 9:24 a.m. Licensed Practical Nurse, Employee E17 was observed coming off the elevator and tearful. LPN, Employee E17 indicated a concern for staffing, and stated the facility is short-staffed all the time. LPN, Employee E17 indicated she is the only nurse on the floor and has 33 residents. LPN, Employee E17 indicated she still has to pass morning medications to the end of her hall.</p> <p>During an interview on 8/8/24, at 11:31 a.m. Scheduler, Employee E27 stated the facility has a staffing problem and recently a lot of new hires stopped showing up, and failed to call or show up before the start of their shift. Scheduler, Employee confirmed the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of four of eight residents (Resident R11, R28, R32, and R69)</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>(continued on next page)</p>		

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F 0725  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Many	28 Pa. Code 201.18(e)(6) Management.  28 Pa. Code: 201.20(a) Staff development.  28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on clinical record review, observations, and staff interview, it was determined the facility failed to provide appropriate care and services to residents receiving medications via feeding tube for two of three residents reviewed (Residents R23 and R29).</p> <p>Finding include:</p> <p>Review of facility policy Enteral Nutrition (nutrition provided via a tube inserted into the stomach) dated 5/18/24, indicated adequate nutritional support through enteral nutrition is provided to residents as ordered. The nurse confirms that orders for enteral nutrition are complete. Complete orders include the enteral nutrition product, and instructions for flushing.</p> <p>Review of Resident R23's clinical record indicated the resident was admitted [DATE], and readmitted [DATE], with diagnoses of metabolic encephalopathy, anxiety, and encounter for attention to gastrostomy.</p> <p>Review of Resident R23's care plan dated 12/27/19, indicated the resident requires a tube feeding due to dysphagia (difficulty swallowing). It was indicated the resident is dependent for tube feeding and water flushes. See physician orders for current feeding orders.</p> <p>Review of Resident R23's physician order dated 10/16/22, indicated to flush the residents G-Tube (gastrostomy tube that is inserted through the belly that brings nutrition directly to the stomach) with 30 cc (a metric unit of volume that is equal to one thousandth of a liter) of water before medication administration, 5cc of water between each medication, and 30cc after medication administration.</p> <p>Review of Resident R23's physician order dated 10/16/22, stated may crush and mix medications together unless contraindicated. Any drug which cannot be crushed, may be given whole in applesauce/pudding.</p> <p>Review of Resident R23's physician order dated 5/10/24, indicated the resident's diet was a puree (a soft, smooth consistency, like a pudding) texture, honey consistency.</p> <p>Review of Resident R23's Minimum Data Set (MDS- a periodic assessment of resident care needs) dated 8/2/24, indicated diagnoses were current. Section K- Swallowing/Nutritional Status indicated the resident has a feeding tube (a soft, flexible plastic tubes through which liquid nutrition travels through your gastrointestinal (GI) tract) and a mechanically altered diet.</p> <p>Review of Resident R29's clinical record indicated the resident was admitted [DATE], with diagnoses of quadriplegia (paralysis that affects all limbs and body from the neck down), anxiety, and depression.</p> <p>Review of Resident R29's care plan dated 5/28/23, indicated the resident requires a tube feeding due to dysphagia (difficulty swallowing). It was indicated to administer tube feeding and water flushes per recommendation and physician orders and monitor for tube dysfunction or malfunction.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R29's physician order dated 5/25/23, indicated to flush the residents G-Tube (gastrostomy tube that is inserted through the belly that brings nutrition directly to the stomach) with 30 milliliters (ml) of water before and after medications and 30-60 ml when starting and stopping tube feeding unless contraindicated.</p> <p>Review of Resident R29's physician order dated 5/25/23, stated may mix all allowable medications and administer via G-tube.</p> <p>Review of Resident R29's Minimum Data Set (MDS- a periodic assessment of resident care needs) dated 2/6/24, indicated the diagnoses were current. Section K- Swallowing/Nutritional Status indicated the resident has a feeding tube (a soft, flexible plastic tubes through which liquid nutrition travels through your gastrointestinal (GI) tract).</p> <p>During an interview on 8/6/24, at 11:06 a.m. Licensed Practical Nurse (LPN), Employee E15 was asked if she mixes medications when administering them through a feeding tube and LPN, Employee E15 stated she goes by what the orders says.</p> <p>During an interview on 8/6/24, at 11:07 a.m. the Director of Nursing (DON) was asked if medications are allowed to be crushed and given together and the DON stated I will have to get you the policy.</p> <p>During an interview on 8/6/24, at 11:25 a.m. the Director of Nursing confirmed residents whose medications are administered via a feeding tube should not have an order to crush and mix medications together. The DON confirmed the facility failed to provide appropriate care and services to residents receiving tube feedings for two of three residents reviewed (Residents R23 and R29).</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 211.12(d)(1) Nursing services.</p>		

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NAME OF PROVIDER OR SUPPLIER  Platinum Ridge Ctr for Rehab & Healing		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Broadview Boulevard Brackenridge, PA 15014	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46167</p> <p>Based on review of facility policies, observations and staff interview, it was determined the facility failed to properly serve food in a sanitary manner to prevent foodborne illness in the Main Kitchen.</p> <p>Findings include:</p> <p>Review of facility policy Sanitation dated 8/24/23, indicated all utensils, shelves and equipment shall be kept clean, maintained in good repair.</p> <p>During an observation in Main Kitchen on 8/4/24, at 11:30 a.m. State Agency was standing at the tray line and felt water dripping onto their shoulder.</p> <p>During an interview on 8/4/24, at 11:30 a.m. State Agency enquired as to where the water was coming from and Dietary Aide Employee E12 replied: It's from the air conditioning vents.</p> <p>During an observation on 8/4/24, at 11:31 a.m. air conditioning ductwork is noted to be approximately one to two feet behind the tray line. Four vents on the ductwork have condensation on the outside of them and are spaced throughout the length of the tray line. All of the four vents appeared to have water dripping from them at sporadic intervals. Directly underneath the ductwork, and dripping vents were two carts that had lids used to cover plates, and other dishes. Dietary Employees were standing at the tray line and would pivot to retrieve the items from these carts behind them for use on resident trays. Noted water droplets were present on top of both of these carts.</p> <p>During an interview on 8/4/24, at 11:45 a.m. Food Service Director Employee confirmed that the facility failed to serve food in a sanitary manner to prevent foodborne illness.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 211.6(c) Dietary services.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>48546</p> <p>Based on a review of facility policies, facility documents, observations, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and Director of Nursing (DON) did not effectively manage the facility to make certain that necessary care and services were provided to residents to ensure safe resident mobility transfers.</p> <p>Findings include:</p> <p>The job description for the Nursing Home Administrator specified the primary purpose of the job position is to manage the Facility in accordance with current applicable federal, state, and local standards, guidelines, and regulations that govern long-term care facilities. To follow all facility policies and apply them uniformly to all employees. To ensure the highest degree of quality care is provided to our residents at all times.</p> <p>The job description of the Director of Nursing specified the primary purpose of the job position is to plan, organize, develop, and direct the overall operation of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times.</p> <p>Based on the findings in this report the facility failed to identify proper transfer statuses of residents and failed to maintain accurate Kardexes (a snapshot of resident care needs) and care plans. This failure resulted in an improper resident transfer, resulting in bruising and a fractured rib. This failure created the potential for additional improper transfers, which placed them in an immediate jeopardy situation. The NHA and DON failed to fulfill essential job duties to ensure that the Federal and State guidelines were followed.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.</p> <p>28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>46167</p> <p>Based on a review of facility documents it was determined that the facility failed to ensure sufficient nursing staff to comply with state laws regarding mandated minimum staffing requirements.</p> <p>Findings include:</p> <p>Review of 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations, S211.12, dated 7/1/23, indicated the following subsections.</p> <p>(f.1) In addition to the director of nursing services, a facility shall provide all of the following:</p> <p>(2) Effective July 1, 2023, a minimum of 1 nurse aide per 12 residents during the day, 1 nurse aide per 12 residents during the evening, and 1 nurse aide per 20 residents overnight.</p> <p>(4) Effective July 1, 2023, a minimum of 1 LPN (licensed practical nurse) per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight.</p> <p>(i) A minimum number of general nursing care hours shall be provided for each 24-hour period as follows:</p> <p>(1) Effective July 1, 2023, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.87 hours of direct resident care for each resident.</p> <p>(3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.</p> <p>Review of facility surveys completed since 9/8/23, through 7/25/24, revealed the following:</p> <p>Survey of 9/8/23:</p> <p>-Failed to provide a minimum of one nurse aide per twelve residents during the day shift, and/or one nurse aid per 20 resident during the night shift on 12 of 21 days (8/19/23, 8/21/23, 8/23/23, 8/24/23, 8/25/23, 8/26/23, 8/27/23, 8/29/23, 8/31/23, 9/2/23, 9/4/23, and 9/7/23. ).</p> <p>-Failed to provide one licensed practical nurse (LPN) per 25 residents during the day shift, one LPN for 30 residents during the evening shift, and one LPN for 40 residents during the night shift on nine of 21 days (8/19/23, 8/20/23, 8/24/23, 8/25/23, 8/27/23, 8/31/23, 9/2/23, 9/3/23, and 9/7/23).</p> <p>Survey 10/10/23:</p> <p>(continued on next page)</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Failed to provide the minimum number of general nursing hours on one of six days (9/17/23).</p> <p>Survey of 11/9/23:</p> <p>-Failed to provide a minimum of one nurse aide per 12 residents during the day and evening shift, and one nurse aide per 20 residents on the night shift for five of eight days (11/3/23, 11/4/24, 11/5/23, 11/6/23, and 11/8/23).</p> <p>-Failed to provide a minimum of one licensed practical nurse (LPN) per 25 residents during the day shift, one LPN for 30 residents during the evening shift and one LPN per 40 residents during the night shift on six of eight days (11/1/23, 11/2/23, 11/3/23, 11/5/23, 11/6/23, and 11/7/23).</p> <p>Survey of 11/27/23:</p> <p>-Failed to provide a minimum of one nurse aide per twelve residents during the day and evening shift for four of seven days (11/21/23, 11/23/23, 11/24/23, 11/26/23).</p> <p>-Failed to provide the minimum number of on LPN for 30 residents on the evening shift, and one LPN for 40 residents during the night shift on three of seven days (11/21/23, 11/22/23, and 11/24/23).</p> <p>Survey of 12/19/23:</p> <p>-Failed to provide a minimum of one nurse aide per twelve residents during the day and evening shift for five of eight days (12/11/23, 12/12/23, 12/13/23, 12/14/23, and 12/15/23).</p> <p>-Failed to provide a minimum of one LPN per 40 residents during the night shift on one of eight days (12/15/23).</p> <p>Survey of 4/24/24:</p> <p>-Failed to provide a minimum of one nurse aide per twelve residents during the day shift for three of 17 days (4/7/24, 4/20/24, and 4/21/24).</p> <p>-Failed to provide a minimum of one LPN for 25 residents during the day shift on one of 17 days (4/23/24).</p> <p>Survey of 5/16/24:</p> <p>-Failed to provide a minimum of one nurse aide per 12 residents during the day shift for two of 33 days (4/24/24, and 4/26/24).</p> <p>Survey of 6/24/24:</p> <p>-Failed to provide a minimum of one nurse aide per 12 residents during the daylight shift for two out of six days (6/15/24, and 6/16/24).</p> <p>Survey of 7/9/24:</p> <p>(continued on next page)</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Failed to provide a minimum of one nurse aide per ten residents on the day shift, one nurse aide per 11 residents on the evening shift, and one nurse aide per 15 residents on the night shift, for three of seven days ( 7/1/24, 7/3/24, and 7/4/24).</p> <p>Survey of 7/25/24:</p> <p>-Failed to provide a minimum of one nurse aide per ten residents on the day shift, one nurse aide per 11 residents on the evening shift, and one nurse aide per 15 residents on the night shift, for four out of five days (7/18/24, 7/19/24, 7/20/24, and 7/21/24).</p> <p>During an interview on 8/8/24, at approximately 1:00 p.m. the Nursing Home Administrator confirmed the facility failed to ensure sufficient nursing staff to comply with state laws regarding mandated minimum staffing requirements.</p> <p>28 Pa. Code 201.14(g) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(e)(1)(2) Management.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46167</p> <p>Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to obtain a diagnosis for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end of life care for two of three residents (Resident R65, and R79) and failed to obtain a physicians order to admit to hospice for one of three residents (R65).</p> <p>Findings include:</p> <p>Review of the facility policy Hospice Program dated 8/24/23, indicated that it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. These responsibilities include communicating with the hospice provider to ensure that the needs of the resident are addressed and met 24 hours per day, and that the hospice coordinated care plan shall be revised and updated as necessary to reflect the resident's current status including, but not limited to diagnosis.</p> <p>Review of the admission record indicated Resident R65 was admitted to the facility on [DATE].</p> <p>Review of Resident R65's MDS (MDS - a periodic assessment of care needs) dated 7/1/24, indicated the diagnoses of high blood pressure, end stage renal disease (ESRD, an inability of the kidneys to filter the blood), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Section O - Special Treatments, Procedures, and Programs indicated hospice care while a resident.</p> <p>Review of Resident R65's clinical record failed to reveal a physician order to admit to hospice, and did not include a diagnosis related to the need of hospice services.</p> <p>Review of Resident R65's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system.</p> <p>During an interview on 8/7/24, at 2:30 p.m. Infection Preventionist Employee E7 stated I don't see one in the orders or careplan.</p> <p>Review of the clinical record indicated Resident R79 was admitted to the facility on [DATE].</p> <p>Review of Resident R79's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking). Section O - Special Treatments, Procedures, and Programs indicated hospice care while a resident.</p> <p>Review of Resident R79's clinical record revealed a physician order dated 3/22/23, to admit to hospice, but did not include a diagnosis related to the need of hospice services.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R79's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to included contact information for the hospice agency and how to access the hospice's 24 hour on-call system.</p> <p>During an interview on 8/6/24, at 2:15 p.m. Infection Preventionist Employee E7 confirmed that the facility failed to obtain a diagnosis for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end of life care for two of three hospice residents (R65, and R79) and failed to obtain a physicians order to admit to hospice for one of three residents (R65).</p> <p>28 Pa. Code 211.2(a) Physician services</p> <p>28 Pa. Code 211.11(d) Resident care plan</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to implement infection control measures and implement enhanced barrier precautions for residents who required tube feedings for two of three residents (Residents R23, and R29).</p> <p>Findings include:</p> <p>Review of facility policy Enhanced Barrier Precautions dated 8/24/23, indicated it is the facility's policy to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. It was indicated staff will receive training on enhanced barrier precautions and an order for enhanced barrier precautions must be implemented for any residents with feeding tubes.</p> <p>Review of Resident R23's clinical record indicated the resident was admitted [DATE], and readmitted [DATE], with diagnoses of metabolic encephalopathy, anxiety, and encounter for attention to gastrostomy.</p> <p>Review of Resident R23's Minimum Data Set (MDS- a periodic assessment of resident care needs) dated 8/2/24, indicated diagnoses were current. Section K- Swallowing/Nutritional Status indicated the resident has a feeding tube (a soft, flexible plastic tubes through which liquid nutrition travels through your gastrointestinal (GI) tract) and a mechanically altered diet.</p> <p>Review of Resident R29's clinical record indicated the resident was admitted [DATE], with diagnoses of quadriplegia (paralysis that affects all limbs and body from the neck down), anxiety, and depression.</p> <p>Review of Resident R29's Minimum Data Set (MDS- a periodic assessment of resident care needs) dated 2/6/24, indicated the diagnoses were current. Section K- Swallowing/Nutritional Status indicated the resident has a feeding tube (a soft, flexible plastic tubes through which liquid nutrition travels through your gastrointestinal (GI) tract).</p> <p>During an interview on 8/5/24, at 11:18 a.m. Licensed Practical Nurse (LPN), Employee E3 stated any residents that are in isolation precautions have a bin with supplies and signage on the door.</p> <p>During an interview on 8/5/24, at 11:22 a.m. LPN, Employee E17 stated she was not educated on enhanced barrier precautions. LPN, Employee E17 Indicated she did not know she had to wear a gown for Resident R23 or R29.</p> <p>During an observation on 8/5/24, at 11:33 a.m. no isolation signage was observed on Resident R23 and R29's door.</p> <p>During an interview on 8/5/24, at 2:58 p.m. Infection Preventionist, Employee E7 confirmed that the facility failed to implement enhanced barrier precautions for two of three residents requiring tube feedings (Resident R23 and Resident R29).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.12 (d)(1)2)(3) Nursing Services.</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>50075</p> <p>Based on review of facility policy, staff education records, and staff interviews, it was determined that the facility failed to conduct at least 12 hours of in-service education, within 12 months of their hire date anniversary, for nurse aides as required for five of five nurse aides (NA Employees E4, E21, E22, E23, and E24)</p> <p>Finding include:</p> <p>A review of the facility policy In-Service Training Program, Nurse Aide dated 8/24/23, indicated all nurse aide personnel participate in regularly scheduled in-service training. Annual in-services include, but not limited to:</p> <ul style="list-style-type: none"> <li>- No less than 12 hours in-service hours per employment year</li> </ul> <p>Review of NA Employee E4's facility provided staff list indicated he was hired on 7/21/20. Review of NA Employee E4's training record for 7/21/23, through 7/21/24, indicated only 10 hours of in-service training.</p> <p>Review of NA Employee E21's facility provided staff list indicated she was hired on 9/30/91. Review of NA Employee E21's training record for 9/30/22, through 9/30/23, indicated only 9.5 hours of in-service training.</p> <p>Review of NA Employee E22's facility provided staff list indicated he was hired on 5/16/22. Review of NA Employee E22's training record for 5/16/23, through 5/16/24, indicated only 10 hours of in-service training.</p> <p>Review of NA Employee E23's facility provided staff list indicated he was hired on 5/12/20. Review of NA Employee E23's training record for 5/12/23, through 5/12/24, indicated only 10 hours of in-service training.</p> <p>Review of NA Employee E24's facility provided staff list indicated he was hired on 11/20/20. Review of NA Employee E24's training record for 11/20/22, through 11/20/23, indicated only 10 hours of in-service training.</p> <p>During an interview on 8/7/24, at 3:03 p.m. the Director of Nursing confirmed that the facility failed to conduct at least 12 hours of in-service education, within 12 months of their hire date anniversary, for nurse aides, as required for five of five nurse aides (NA Employees E4, E21, E22, E23, and E24).</p> <p>28 Pa. Code: 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code: 201.20(c) Staff Development.</p>

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>50075</p> <p>Based on review of facility documents, employee education records, and staff interview, it was determined that the facility failed to provide training on behavioral health for five of five staff members (Nurse Aide Employee E4, E21, E22, E23, and E24).</p> <p>Findings include:</p> <p>Review of the Facility assessment dated , First Quarter, indicated staff training/education will be completed by all nursing staff and will be an ongoing-annual training requirement. Education listed included, but not limited to:</p> <ul style="list-style-type: none"> <li>- Behavioral Health</li> </ul> <p>Review of the policy In-Service Training Program, Nurse Aide dated 8/24/23 indicated that all personnel are required to attend regularly scheduled in-service training. Records are filed in the employee ' s personnel file or are maintained by the department supervisor.</p> <p>Review of Nurse Aide (NA) Employee E4's facility provided staff list indicated she was hired on 7/21/20. Review of NA Employee E4's training record for 7/21/23, through 7/21/24, did not include training on behavioral health.</p> <p>Review of Nurse Aide (NA) Employee E21's facility provided staff list indicated she was hired on 9/30/91. Review of NA Employee E21s training record for 9/30/22, through 9/30/23, did not include training on behavioral health.</p> <p>Review of Nurse Aide (NA) Employee E22's facility provided staff list indicated she was hired on 5/16/22. Review of NA Employee E22's training record for 5/16/23, through 5/16/24, did not include training on behavioral health.</p> <p>Review of Nurse Aide (NA) Employee 23's facility provided staff list indicated she was hired on 5/12/20. Review of NA Employee E23's training record for 5/12/23, through 5/12/24, did not include training on behavioral health.</p> <p>Review of Nurse Aide (NA) Employee E24's facility provided staff list indicated she was hired on 11/20/20. Review of NA Employee E24's training record for 11/20/22, through 11/20/23, did not include training on behavioral health.</p> <p>During an interview on 8/7/24, at 3:05 p.m. Director of Nursing confirmed that the facility failed to provide training on behavioral health for five of five staff members (Nurse Aide Employee E4, E21, E22, E23, and E24).</p> <p>28 Pa Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa Code: 201.18 (b)(1) Management.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Platinum Ridge Ctr for Rehab & Healing		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa Code: 201.20 (a)(c) Staff development.</p>		