STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395032	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McMurray Hills Manor	249 West McMurray Road McMurray, PA 15317

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 39311 Based on facility policy, clinical record review and staff interview, 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 24 of 31 residents (Residents R1. R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, and R24). Findings include: Review of the facility policy Transfer and discharge date d 6/20/24, previously reviewed 1/30/23, indicated for emergency discharges, the Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman. Review of the facility provided Hospital Tracking Portal report, reviewed for the dates 6/1/24, through 9/30/24, included the following information: Resident R1 was transferred emergently to the hospital on 6/9/24. Resident R2 was transferred emergently to the hospital on 6/11/24. Resident R3 was transferred emergently to the hospital on 6/24/24. Resident R4 was transferred emergently to the hospital on 6/30/24. Resident R5 was transferred emergently to the hospital on 7/3/24. Resident R6 was transferred emergently to the hospital on 7/5/24. Resident R7 was transferred emergently to the hospital on 7/8/24, and 7/12/24. Resident R8 was transferred emergently to the hospital on 7/26/24, and 7/31/24. Resident R9 was transferred emergently to the hospital on 8/1/24, and 8/16/24. Resident R10 was transferred emergently to the hospital on 8/2/24. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R11 was transferred emergently to the hospital on 8/8/24. Resident R12 was transferred emergently to the hospital on 8/18/24. Resident R13 was transferred emergently to the hospital on 8/22/24. Resident R14 was transferred emergently to the hospital on 8/26/24. Resident R15 was transferred emergently to the hospital on 8/26/24. Resident R16 was transferred emergently to the hospital on 9/5/24. Resident R17 was transferred emergently to the hospital on 9/10/24. Resident R18 was transferred emergently to the hospital on 9/11/24. Resident R19 was transferred emergently to the hospital on 9/17/24. Resident R20 was transferred emergently to the hospital on 9/17/24, and 9/23/24. Resident R21 was transferred emergently to the hospital on 9/21/24. Resident R22 was transferred emergently to the hospital on 9/21/24. Resident R23 was transferred emergently to the hospital on 9/27/24. Resident R24 was transferred emergently to the hospital on 9/29/24. Review of the facility provided Discharge Log for June, July, August, and September 2024 failed to include the above residents. During an interview on 10/9/24, at approximately 12:30 p.m. the Business Officer Manager confirmed the above resident transfers were not communicated to the Office of the Long-Term Care Ombudsman. During an interview on 10/9/24 at 1:40 p.m. the Director of Nursing (DON) confirmed the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for 24 of 31 residents. 28 Pa. Code 201.29(a)(c)(3)(2) Resident rights.