Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395090	A. Building B. Wing	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windber Woods Senior Living & Rehabilitation Ctr	277 Hoffman Avenue Windber, PA 15963

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 31760 Based on review of Pennsylvania's Nursing Practice Act, residents' clinical records, personnel files, and the licensed practical nurse job description, as well as staff interviews, it was determined that the facility failed to ensure that the nurse documented treatments accurately for one of 10 residents reviewed (Resident 6). This deficiency was cited as past non-compliance. Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.148. Standards of nursing conduct (a)(5)(8) indicated that the licensed practical nurse was to document and maintain accurate records. Not to falsify or knowingly make incorrect entries into the patient's record or other related documents. The facility's licensed practical nurse job description, dated May 8, 2018, revealed that the licensed practical nurse was to chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to the care, and perform routine charting duties as required and in accordance with the facility's established charting and documentation policies and procedures. Physician's order for Resident 6, dated January 10, 2024, revealed that staff were to cleanse the resident's left shin with wound cleanser, then apply Xeroform gauze (a sterile, non-adhering protective dressing consisting of absorbent, fine-mesh gauze impregnated with a petrolatum), and secure with border foam dressing (a highly absorbent self-adherent silicone foam dressing) every other day and as needed on dayshift for an abrasion (an area damaged by scraping or wearing away). A review of Resident 6's January 2024 Treatment Administration Record (TAR) revealed that Licensed Practical Nurse 1 documented as having completed the treatment to Resident 6's left shin on January 14, 2024. (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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, a review of Licensed Practical Nurse 1's personnel file revealed a disciplinary action, dated January 15, 2024, indicating that on the morning of January 15, 2024, as the wound nurse was completing treatments on Resident 6 and it was noted that the resident had an intact dressing on the left lower leg dated January 12, 2024. According to physician's orders, the treatment to Resident 6's left lower leg wound was ordered for every other day, on day shift (7:00 a.m. to 3:00 p.m.) and should have been completed on January 14, 2024. However, as noted by the intact dressing, this treatment was not performed since January 12, 2024. Upon further investigation, Resident 6's TAR indicated that the treatment had been completed by Licensed Practical Nurse 1 on January 14, 2024. Interview with the Nursing Home Administrator on March 11, 2024, at 4:00 p.m. confirmed that Licensed Practical Nurse 1 did not complete Resident 6's treatment as ordered on January 14, 2024, and confirmed that she documented the treatment as being completed on the resident's TAR. Following the investigation on January 15, 2024, the facility's corrective actions included: Licensed Practical Nurse 1 was re-educated on professional standards related to completing treatments as ordered and accurate documentation. A whole-house wound treatment assessment was completed on residents to identify any issues. Staff education on the completion of treatments as ordered and documentation was completed. Audits were being completed to identify any wound treatment/documentation issues. The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. Review of the facility's corrective actions revealed that they were in compliance with F658 on March 4, 2024. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 31760 Based on review of clinical records and personnel files, as well as staff interviews, it was determined that the facility failed to ensure that residents received care and treatment in accordance with professional standards of practice by failing to ensure that physician's orders were followed for two of 10 residents reviewed (Residents 4, 6). Findings include: A physician's progress note, dated January 25, 2024, revealed that Resident 4 was seen for a rash on his back that began suddenly and was itchy and red. The plan was to apply 0.025 percent Triamcinolone cream to the rash twice a day; however, there was no physician's order that included the recommended treatment. A review of Resident 4's Treatment Administration Record (TAR) for January and February 2024 revealed that there was no documented evidence that Triamcinolone cream was applied to the resident's rash as recommended by the physician. Interview with Registered Nurse 2 on March 11, 2024, at 2:58 p.m. confirmed that she missed the physician's order and did not enter it into the electric medical record. Interview with the Nursing Home Administrator on March 11, 2024, at 2:50 p.m. confirmed that Resident 4 did not receive Triamcinolone to the rash on his back as recommended by the physician on January 25, 2024. A care plan for Resident 6, dated January 31, 2024, revealed that the resident had a potential for pressure ulcer (areas of damage to the skin and the tissue underneath) development and staff were to complete treatments as ordered. Physician's orders for Resident 6, dated January 10, 2024, revealed that staff were to cleanse the resident's left shin with wound cleanser, then apply Xeroform gauze (a sterile, non-adhering protective dressing consisting of absorbent, fine-mesh gauze impregnated with a petrolatum), and secure with border foam dressing (a highly absorbent self-adherent silicone foam dressing) every other day and as needed on dayshift for an abrasion (an area damaged by scraping or wearing away). Review of Licensed Practical Nurse 1's personnel file revealed a disciplinary action, dated January 15, 2024, which indicated that on the morning of January 15, 2024, as the wound nurse was completing treatments on Resident 6, it was noted that the resident had an intact dressing on the left lower leg with a noted date of January 12, 2024. According to the physician's orders, the treatment to Resident 6's left lower leg wound was ordered for every other day on the day shift (7:00 a.m. to 3:00 p.m.) and should have been completed on January 14, 2024. However, as noted by the intact dressing, the treatment was not performed since January 12, 2024, per to the physician's order. Interview with the Nursing Home Administrator on March 11, 2024, at 4:00 p.m. confirmed that Licensed Practical Nurse 1 did not complete Resident 6's treatment as ordered on January 14, 2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31760 Based on review of clinical records and investigation reports, as well as staff interviews, it was determined that the facility failed to provide an environment that was free of accident hazards to residents who were at risk for falls for one of 10 residents reviewed (Resident 6), resulting in a fall. This deficiency was cited as past non-compliance. Findings include: A significant change in condition Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated December 28, 2023, revealed that the resident was understood and could understand. The resident's care plan, dated November 2, 2023, revealed that he was at risk for falls related to weakness/balance problems and poor safety awareness, and required assistance but does not always ask for assistance with transfers/ambulation (walking). Physician's orders for Resident 6, dated November 20, 2023, included an order for the resident to always have bed and chair alarms. Staff was to check the function and placement every shift. A nursing note for Resident 6, dated November 22, 2023, at 11:55 a.m. revealed that the writer was called to the unit by staff stating that the resident had fallen. Upon entering the resident's room, the resident was found sitting on the floor on his buttocks beside his wheelchair with his back against the bed and his legs outstretched in front of him. The chair alarm was not on the resident's wheelchair at the time of the fall. The resident stated he slid out of the wheelchair. The resident was assessed for injury and was found to have no injuries. A nursing note at 12:11 p.m. revealed that the writer heard the resident hollering and found the resident on the floor in front of his wheelchair. No alarm was sounding, and there was not an alarm present. The resident was transferred out of his recliner by therapy and the alarm was not placed on his wheelchair. A fall investigation report for Resident 6, dated November 22, 2023, revealed that upon investigation the resident's chair alarm was not under him as therapy transferred the resident into his wheelchair. Therapy was educated on the importance of ensuring that when they are transferring residents their alarms are in place. Interview with the Nursing Home Administrator on March 11, 2024, at 5:05 p.m. confirmed that therapy transferred Resident 6 from his recliner and into his wheelchair without placing the chair alarm on the resident's wheelchair. She indicated that therapy should have placed the chair alarm on the resident's wheelchair. Following the investigation on November 22, 2023, the facility's corrective actions included: Therapy staff was re-educated on ensuring the placement of alarms. A whole-house assessment was completed on residents with alarms to identify any issues. Staff education on ensuring alarms are present was completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Audits were being completed to identify any issues with alarm placement. The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. Review of the facility's corrective actions revealed that they were in compliance with F689 on March 1, 2024. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 31760 Based on review of residents' clinical records, personnel files, the licensed practical nurse job description, as well as staff interviews, it was determined that the facility failed to ensure that residents' clinical records were complete and accurately documented for one of 10 residents reviewed (Resident 6). This deficiency was cited as past non-compliance. Findings include: The facility's licensed practical nurse job description, dated May 8, 2018, revealed that the licensed practical nurse was to chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to the care. Perform routine charting duties as required and in accordance with the facility's established charting and documentation policies and procedures. Physician's order for Resident 6, dated January 10, 2024, revealed that staff was to cleanse the resident's left shin with wound cleanser, then apply Xeroform gauze (a sterile, non-adhering protective dressing consisting of absorbent, fine-mesh gauze impregnated with a petrolatum) and secure with border foam dressing (a highly absorbent self-adherent silicone foam dressing) every other day and as needed on dayshift for an abrasion (an area damaged by scraping or wearing away). A review of Resident 6's January 2024 Treatment Administration Record (TAR) revealed that Licensed Practical Nurse 1 documented as having completed the treatment to Resident 6's left shin on January 14, 2024. However, a review of Licensed Practical Nurse 1's personnel file revealed a disciplinary action, dated January 15, 2024, indicating that on the morning of January 15, 2024, as the wound nurse was completing treatments on Resident 6, it was noted that the resident had an intact dressing on the left lower leg dated January 12, 2024. According to physician's orders, the treatment to Resident 6's left lower leg wound was ordered for every other day on day shift(7:00 a.m. to 3:00 p.m.) and should have been completed on January 14, 2024. However, as noted by the intact dressing, this treatment was not performed since January 12, 2024. Upon further investigation, Resident 6's TAR indicated that the treatment had been completed by Licensed Practical Nurse 1 on January 14, 2024 Interview with the Nursing Home Administrator on March 11, 2024, at 4:00 p.m. confirmed that Licensed Practical Nurse 1 did not complete Resident 6's treatment as ordered on January 14, 2024, and confirmed that she documented the treatment as being completed on the resident's TAR. Following the investigation on January 15, 2024, the facility's corrective actions included: Licensed Practical Nurse 1 was re-educated on accurate documentation. A whole-house assessment was completed on residents with wound treatments to identify any issues. Staff education on the completion of treatments as ordered and documentation was completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Audits were being completed to identify any wound treatment/documentation issues. The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. Review of the facility's corrective actions revealed that they were in compliance with F842 on March 4, 2024. 28 Pa. Code 211.5(f) Clinical Records.