STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395164	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John Specialty Care Center	500 Wittenberg Way Mars, PA 16046

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, facility documentation, clinical record review, and staff interview, it was determined that the facility failed to make certain that residents were free from abuse for one of five residents (Resident R2) and failed to identify concerns as abuse for four of five residents (Residents R3, R4, R5, and R6). Finding include: Review of facility policy Abuse, Prevention of Resident Abuse dated 08/30/24, indicated all incidents of actual, alleged, or suspected abuse, neglect, theft, misappropriation of resident property, or injury of unknown origin will be promptly reported and thoroughly investigated. Review of Title 42 code of Federal Regulations (CFR) S483.12(a)(1) indicated Abuse, is defined at S483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/15/24 indicated diagnoses of high blood pressure, hip fracture, and dementia (a group of symptoms that affects memory, thinking, and interferes with daily life). Review of incidents submitted to the State dated 6/2/24, indicated, The daylight Nurse Aide (NA) went into room to provide morning care to Resident R2. When she tried to pull the flat sheet down so she could remove her gown and bathe her, she was not able to pull that flat sheet down. When she looked to see why she could not pull it down she found it to be tied to the bed on both sides. She immediately notified the nurse who observed the same situation and immediately notified the Manager on Duty. The MOD called me, the DON, and reported the situation. 3 alleged perpetrators were identified. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an undated witness statement completed by Licensed Practical Nurse (LPN) E5 stated, On the night of June 1st, the aides on shift, NA Employee E1, NA Employee E2, and NA Employee 3 started the shift by taking the dinner trays off the unit together. When they returned they started rounds on the front hall then worked their way to the back hall going in each room together. The rounds took from 7:45 p.m. until almost midnight. When finished they went to the resident dining room to sit for the remainder of the night. When doing rounds in the morning they started at 4 a.m. going into each resident's rooms together. They were talking loudly and laughing to where they could be heart at the nurse's station waking up several residents in the process. Review of a witness statement obtained on 6/2/24, from Certified Therapeutic Recreation Specialist (CTRS) Employee E6 stated, On 6/2/24 at approximately 9:50 a.m., writer was leaving the unit when a nurse asked me to return. The nurse then showed me photos from Resident R2's room. The photos showed a bed sheet tied to each side of the handrail to keep the resident in the bed. Review of a telephonic witness statement obtained on 6/3/24, from NA Employee E1 stated, NA Employee E1 reported that she had first changed Resident R2 on her own around 8 pm because she was taking trash back and noticed her with her hip abductor off and half hanging off the bed. She reported that the resident had a bowel movement and had her hands in her brief, so she had stool on her fingers. She reports that she changed her, put the hip abductor back together and in place with resident, put the TV on and placed the bed in the low position. She then said that she reported to the nurse that 288 was not a good room for Resident R2 as she is very active at night and seems agitated. When questioned regarding the state of the resident's skin she reported an old bruise to the left shoulder and excoriation to her buttocks with bleeding. As NA Employee E1 kept speaking she reported that she had first gone in the room because she heard the red cup hit the floor. She stated that the resident had thrown her red cup of water and Kleenexes on the floor and she went in and found that she had a bowel movement and stool on her fingers. NA Employee E1 reports that Resident R2 was not on her assignment, she had the left side of the hall. She then reported that she checked on Resident R2 four more times through the night with the last time being at 7 am. She also reports that she tucked the sheets under the pad under Resident R2's buttocks to keep her from reaching into her brief again. Review of a telephonic witness statement obtained on 6/3/24, from NA Employee E2 stated, NA Employee E2 reports that on first rounds her and NA Employee E1 found the resident sitting up in bed, noted she had a bowel movement and had stool on her fingers from sticking her hands in her brief. NA Employee E2 reports that NA Employee E1 tucked the blankets in under resident on last rounds. She then stated that NA Employee E3 went in and checked and changed Resident R2 at 6:45ish. She reports that there was no skin issues at all. She said NA Employee E1 did the midnight change and that she was only in there the one time around 8 pm with NA Employee E1 - she said NA Employee E1 did all the other check and changes that night. She states that she was told in report that the resident had slept all day. She said that Friday night they had to keep putting her hip abductor back on. She reported that the resident was not restless at all on Saturday night. She states when the blankets were tucked under Resident R1, her arms were on top of the blankets. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a telephonic witness statement obtained on 6/3/24, from NA Employee E3 stated, NA Employee E3 stated she was unable to provide information regarding Resident R2 on Saturday night. She then reported that NA Employee E1, NA Employee E2, and herself did rounds together at the beginning of the shift because they help each other. She then reported that she went in one time by herself to change Resident R2 and it was closer to morning time. She then stated that she did not need changed but the call bell was on the floor so she laid the call bell on top of her covers. When asked if the resident was restless or seemed to be in pain Saturday night she replied no, not really. She was then asked to clarify not really and she stated nothing she was aware of. During an interview on 6/18/24, at 1:27 p.m. Human Resources Employee E8 stated, NA Employee E1, NA Employee E2, and NA Employee E3 were suspended on 6/2/24 after being identified as the alleged perpetrators and all three were terminated on 6/10/24. They were suspended from 6/2/24 until their terminations on 6/10/24 and did not work in the facility during that period. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (too much sugar in the blood), and muscle weakness. Review of investigation documents dated 6/2/24, indicated, Resident R3 stated she turned her light on at 9:30 p.m. and the aides did not come in until after 11:30 p.m. She stated three aides came into her room to put her to bed and they talked to each other and not her. They were very rough and would not help her unless she asked specifically to be turned or moved. She stated one of the aides said, I thought this place was supposed to teach people how to take care of themselves. She also stated the white one stated, I'm not doing that you didn't say please. She found all three aides to be extremely rude and that they were treating her like a number not a person. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and anxiety (a feeling of worry, nervousness, or unease). Review of investigation documents dated 6/2/24 indicated, Resident R4 stated that the aides on nightshift were extremely rough and hurt her leg last night. She stated that they did not speak to her they only spoke to each other and the conversations were conversations that should not occur in front of residents. They were nasty with each other saying that they did not want to be at work and they are going to start calling off. Resident R4 felt that these conversations did not need to happen in front of her and she would like for the staff to acknowledge her when doing care on her. Review of an undated statement completed by LPN Employee E5 stated, This nurse went in to assist Resident R4 and she stated, Those two aides that were in here are something else. I asked her what she meant and she started whispering that they are something else. I closed the door and asked her again what she meant and was everything ok. She then stated that the two girls were rough with her and hit her leg off the bed. She stated she screamed out in pain and they told her she was fine and nothing was wrong. She stated they were very rough with her. I asked if she wanted to do an incident report and she seemed hesitant. She just repeated that they were very rough. Review of the clinical record revealed Resident R5 was admitted to the facility on [DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R5's MDS dated [DATE], indicated diagnoses of high blood pressure, history of falling, and muscle weakness. Review of investigation documents dated 6/2/24 indicated, Resident R5 stated her care was 'okay but she is very rough. Please do not repeat that.' Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle weakness, and constipation. Review of investigation documents dated 6/2/24 indicated, Resident R6 stated the staff was not nice to her last night. They were mad that she was unable to hold the lift and strapped her feet down because they wouldn't stay on her leg rests. Resident R6 was unable to tell me what they said that was 'not nice.' During an interview on 6/18/24, at 2:09 p.m. the Director of Nursing (DON) confirmed that the facility did not identify Resident R3, R4, R5, and R6's concerns as abuse. During an interview on 6/18/24, at 4:05 p.m. the Nursing Home Administrator and DON confirmed that the facility failed to make certain that residents were free from abuse for one of five residents (Resident R2) and failed to identify concerns as abuse for four of five residents (Residents R3, R4, R5, and R6.) 28. Pa Code 201.14(a) Responsibility of licensee. 28. Pa Code 201.18(b)(1)(e)(1) Management. 28. Pa. Code 211.12(d)(1)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical records, facility documents and staff interview, it was determined that the facility failed to make certain a resident was free from a physical restraint for one of five residents reviewed (Resident R2). Findings include: Review of facility policy Physical and Chemical Restraints dated 8/30/24, indicated physical restraints are defined as any manual, physical, or mechanical device, material, or equipment attached to adjacent to the resident's body that he cannot remove easily which restricts freedom of movement or normal access to one's body. The use of any physical restraint should only be an intervention of last resort where there is an imminent risk of harm. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/15/24 indicated diagnoses of high blood pressure, hip fracture, and dementia (a group of symptoms that affects memory, thinking, and interferes with daily life). Review of incidents submitted to the State dated 6/2/24, indicated, The daylight Nurse Aide (NA) went into room to provide morning care to Resident R2. When she tried to pull the flat sheet down so she could remove her gown and bathe her, she was not able to pull that flat sheet down. When she looked to see why she could not pull it down she found it to be tied to the bed on both sides. She immediately notified the nurse who observed the same situation and immediately notified the Manager on Duty. The MOD called me, the DON, and reported the situation. 3 alleged perpetrators were identified. Review of a witness statement obtained on 6/2/24, from Certified Therapeutic Recreation Specialist (CTRS) Employee E6 stated, On 6/2/24 at approximately 9:50 a.m., writer was leaving the unit when a nurse asked me to return. The nurse then showed me photos from Resident R2's room. The photos showed a bed sheet tied to each side of the handrail to keep the resident in the bed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a telephonic witness statement obtained on 6/3/24, from NA Employee E1 stated, NA Employee E1 reported that she had first changed Resident R2 on her own around 8 pm because she was taking trash back and noticed her with her hip abductor off and half hanging off the bed. She reported that the resident had a bowel movement and had her hands in her brief, so she had stool on her fingers. She reports that she changed her, put the hip abductor back together and in place with resident, put the TV on and placed the bed in the low position. She then said that she reported to the nurse that 288 was not a good room for Resident R2 as she is very active at night and seems agitated. When questioned regarding the state of the resident's skin she reported an old bruise to the left shoulder and excoriation to her buttocks with bleeding. As NA Employee E1 kept speaking she reported that she had first gone in the room because she heard the red cup hit the floor. She stated that the resident had thrown her red cup of water and Kleenexes on the floor and she went in and found that she had a bowel movement and stool on her fingers. NA Employee E1 reports that Resident R2 was not on her assignment, she had the left side of the hall. She then reported that she checked on Resident R2 four more times through the night with the last time being at 7 am. She also reports that she tucked the sheets under the pad under Resident R2's buttocks to keep her from reaching into her brief again. Review of a telephonic witness statement obtained on 6/3/24, from NA Employee E2 stated, NA Employee E2 reports that on first rounds her and NA Employee E1 found the resident sitting up in bed, noted she had a bowel movement and had stool on her fingers from sticking her hands in her brief. NA Employee E2 reports that NA Employee E1 tucked the blankets in under resident on last rounds. She then stated that NA Employee E3 went in and checked and changed Resident R2 at 6:45ish. She reports that there was no skin issues at all. She said NA Employee E1 did the midnight change and that she was only in there the one time around 8 pm with NA Employee E1 - she said NA Employee E1 did all the other check and changes that night. She states that she was told in report that the resident had slept all day. She said that Friday night they had to keep putting her hip abductor back on. She reported that the resident was not restless at all on Saturday night. She states when the blankets were tucked under Resident R1, her arms were on top of the blankets. Review of a telephonic witness statement obtained on 6/3/24, from NA Employee E3 stated, NA Employee E3 stated she was unable to provide information regarding Resident R2 on Saturday night. She then reported that NA Employee E1, NA Employee E2, and herself did rounds together at the beginning of the shift because they help each other. She then reported that she went in one time by herself to change Resident R2 and it was closer to morning time. She then stated that she did not need changed but the call bell was on the floor so she laid the call bell on top of her covers. When asked if the resident was restless or seemed to be in pain Saturday night she replied no, not really. She was then asked to clarify not really and she stated nothing she was aware of. During an interview on 6/18/24, at 1:27 p.m. Human Resources Employee E8 stated, NA Employee E1, NA Employee E2, and NA Employee E3 were suspended on 6/2/24 after being identified as the alleged perpetrators and all three were terminated on 6/10/24. They were suspended from 6/2/24 until their terminations on 6/10/24 and did not work in the facility during that period. During an interview on 6/18/24, at 4:05 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain a resident was free from a physical restraint for one of five residents reviewed (Resident R2). 28 Pa. Code: 201.14(a) Responsibility of licensee. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 201.29(a) Resident rights. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to implement the written policies and procedures to ensure a complete and thorough investigation and timely reporting was completed for four of four abuse allegations (Residents R3, R4, R5, and R6). Finding include: Review of facility policy Abuse, Prevention of Resident Abuse dated 08/30/24, indicated all incidents of actual, alleged, or suspected abuse, neglect, theft, misappropriation of resident property, or injury of unknown origin will be promptly reported and thoroughly investigated. All alleged/suspected violations and all substantiated incidents of abuse, neglect, theft, exploitation or misappropriation of resident property, will be promptly reported to all appropriate state licensing agencies and other entities or individuals as may be required by law. Review of Title 42 Code of Federal Regulations (CFR) S483.12(c) states in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (too much sugar in the blood), and muscle weakness. Review of investigation documents dated 6/2/24, indicated, Resident R3 stated she turned her light on at 9:30 p.m. and the aides did not come in until after 11:30 p.m. She stated three aides came into her room to put her to bed and they talked to each other and not her. They were very rough and would not help her unless she asked specifically to be turned or moved. She stated one of the aides said, I thought this place was supposed to teach people how to take care of themselves. She also stated the white one stated, I'm not doing that you didn't say please. She found all three aides to be extremely rude and that they were treating her like a number not a person. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and anxiety (a feeling of worry, nervousness, or unease). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of investigation documents dated 6/2/24 indicated, Resident R4 stated that the aides on nightshift were extremely rough and hurt her leg last night. She stated that they did not speak to her they only spoke to each other and the conversations were conversations that should not occur in front of residents. They were nasty with each other saying that they did not want to be at work and they are going to start calling off. Resident R4 felt that these conversations did not need to happen in front of her and she would like for the staff to acknowledge her when doing care on her. Review of an undated statement completed by LPN Employee E5 stated, This nurse went in to assist Resident R4 and she stated, Those two aides that were in here are something else. I asked her what she meant and she started whispering that they are something else. I closed the door and asked her again what she meant and was everything ok. She then stated that the two girls were rough with her and hit her leg off the bed. She stated she screamed out in pain and they told her she was fine and nothing was wrong. She stated they were very rough with her. I asked if she wanted to do an incident report and she seemed hesitant. She just repeated that they were very rough. Review of the clinical record revealed Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's MDS dated [DATE], indicated diagnoses of high blood pressure, history of falling, and muscle weakness. Review of investigation documents dated 6/2/24 indicated, Resident R5 stated her care was 'okay but she is very rough. Please do not repeat that.' Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle weakness, and constipation. Review of investigation documents dated 6/2/24 indicated, Resident R6 stated the staff was not nice to her last night. They were mad that she was unable to hold the lift and strapped her feet down because they wouldn't stay on her leg rests. Resident R6 was unable to tell me what they said that was 'not nice.' During an interview on 6/18/24, at 2:09 p.m. the Director of Nursing (DON) confirmed that the facility did not identify Resident R3, R4, R5, and R6's concerns as abuse, did not complete investigations regarding the resident statements, and did not report the allegations of abuse to the State. During an interview on 6/18/24, at 4:-05 p.m. the Nursing Home Administrator and DON confirmed that the facility failed to implement the written policies and procedures to ensure a complete and thorough investigation and timely reporting was completed for four of four abuse allegations (Residents R3, R4, R5, and R6). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, reports submitted to the State, and staff interview, it was determined that the facility failed to report an allegation of abuse in the required timeframe for four of four residents (Residents R3, R4, R5, and R6). Findings include: Review of facility policy Abuse, Prevention of Resident Abuse dated 08/30/24, indicated all incidents of actual, alleged, or suspected abuse, neglect, theft, misappropriation of resident property, or injury of unknown origin will be promptly reported and thoroughly investigated. All alleged/suspected violations and all substantiated incidents of abuse, neglect, theft, exploitation or misappropriation of resident property, will be promptly reported to all appropriate state licensing agencies and other entities or individuals as may be required by law. Review of Title 42 Code of Federal Regulations (CFR) S483.12(c) states in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (too much sugar in the blood), and muscle weakness. Review of investigation documents dated 6/2/24, indicated, Resident R3 stated she turned her light on at 9:30 p.m. and the aides did not come in until after 11:30 p.m. She stated three aides came into her room to put her to bed and they talked to each other and not her. They were very rough and would not help her unless she asked specifically to be turned or moved. She stated one of the aides said, I thought this place was supposed to teach people how to take care of themselves. She also stated the white one stated, I'm not doing that you didn't say please. She found all three aides to be extremely rude and that they were treating her like a number not a person. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and anxiety (a feeling of worry, nervousness, or unease). (continued on next page)

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	395164	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John Specialty Care Center	500 Wittenberg Way Mars, PA 16046

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of investigation documents dated 6/2/24 indicated, Resident R4 stated that the aides on nightshift were extremely rough and hurt her leg last night. She stated that they did not speak to her they only spoke to each other and the conversations were conversations that should not occur in front of residents. They were nasty with each other saying that they did not want to be at work and they are going to start calling off. Resident R4 felt that these conversations did not need to happen in front of her and she would like for the staff to acknowledge her when doing care on her. Review of an undated statement completed by LPN Employee E5 stated, This nurse went in to assist Resident R4 and she stated, Those two aides that were in here are something else. I asked her what she meant and she started whispering that they are something else. I closed the door and asked her again what she meant and was everything ok. She then stated that the two girls were rough with her and hit her leg off the bed. She stated she screamed out in pain and they told her she was fine and nothing was wrong. She stated they were very rough with her. I asked if she wanted to do an incident report and she seemed hesitant. She just repeated that they were very rough. Review of the clinical record revealed Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's MDS dated [DATE], indicated diagnoses of high blood pressure, history of falling, and muscle weakness. Review of investigation documents dated 6/2/24 indicated, Resident R5 stated her care was 'okay but she is very rough. Please do not repeat that.' Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle weakness, and constipation. Review of investigation documents dated 6/2/24 indicated, Resident R6 stated the staff was not nice to her last night. They were mad that she was unable to hold the lift and strapped her feet down because they wouldn't stay on her leg rests. Resident R6 was unable to tell me what they said that was 'not nice.' During an interview on 6/18/24, at 2:09 p.m. the Director of Nursing (DON) confirmed that the facility did not identify Resident R3, R4, R5, and R6's concerns as abuse, did not complete investigations regarding the resident statements, and did not report the allegations of abuse to the State. During an interview on 6/18/24, at 4:05 p.m. the Nursing Home Administrator and DON confirmed that the facility failed to report an allegation of abuse in the required timeframe for four of four residents (Residents R3, R4, R5, and R6). 28 Pa Code: 201.14 (a) Responsibility of Management 28 Pa Code: 201.18 (e)(1) Management.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, facility documentation, and staff interview, it was determined that the facility failed to fully investigate allegations of abuse for four of four residents (Residents R3, R4, R5, and R6). Findings include: Review of facility policy Abuse, Prevention of Resident Abuse dated 08/30/24, indicated all incidents of actual, alleged, or suspected abuse, neglect, theft, misappropriation of resident property, or injury of unknown origin will be promptly reported and thoroughly investigated. Review of Title 42 Code of Federal Regulations (CFR) S483.12 (c) indicated In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: S483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. S483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. S483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (too much sugar in the blood), and muscle weakness. Review of investigation documents dated 6/2/24, indicated, Resident R3 stated she turned her light on at 9:30 p.m. and the aides did not come in until after 11:30 p.m. She stated three aides came into her room to put her to bed and they talked to each other and not her. They were very rough and would not help her unless she asked specifically to be turned or moved. She stated one of the aides said, I thought this place was supposed to teach people how to take care of themselves. She also stated the white one stated, I'm not doing that you didn't say please. She found all three aides to be extremely rude and that they were treating her like a number not a person. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and anxiety (a feeling of worry, nervousness, or unease). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of investigation documents dated 6/2/24 indicated, Resident R4 stated that the aides on nightshift were extremely rough and hurt her leg last night. She stated that they did not speak to her they only spoke to each other and the conversations were conversations that should not occur in front of residents. They were nasty with each other saying that they did not want to be at work and they are going to start calling off. Resident R4 felt that these conversations did not need to happen in front of her and she would like for the staff to acknowledge her when doing care on her. Review of an undated statement completed by LPN Employee E5 stated, This nurse went in to assist Resident R4 and she stated, Those two aides that were in here are something else. I asked her what she meant and she started whispering that they are something else. I closed the door and asked her again what she meant and was everything ok. She then stated that the two girls were rough with her and hit her leg off the bed. She stated she screamed out in pain and they told her she was fine and nothing was wrong. She stated they were very rough with her. I asked if she wanted to do an incident report and she seemed hesitant. She just repeated that they were very rough. Review of the clinical record revealed Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's MDS dated [DATE], indicated diagnoses of high blood pressure, history of falling, and muscle weakness. Review of investigation documents dated 6/2/24 indicated, Resident R5 stated her care was 'okay but she is very rough. Please do not repeat that.' Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle weakness, and constipation. Review of investigation documents dated 6/2/24 indicated, Resident R6 stated the staff was not nice to her last night. They were mad that she was unable to hold the lift and strapped her feet down because they wouldn't stay on her leg rests. Resident R6 was unable to tell me what they said that was 'not nice.' During an interview on 6/18/24, at 2:09 p.m. the Director of Nursing (DON) confirmed that the facility did not identify Resident R3, R4, R5, and R6's concerns as abuse, did not complete investigations regarding the resident statements, and did not report the allegations of abuse to the State. During an interview on 6/18/24, at 4:05 p.m. the Nursing Home Administrator and DON confirmed that the facility failed to fully investigate allegations of abuse for four of four residents (Residents R3, R4, R5, and R6). 28 Pa Code: 201.18 (e)(1)(2) Management 28 Pa Code: 201.29 (a)(c)(d) Resident Rights 28 Pa Code: 211.12 (a)(c)(d)(1)(3)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to make certain that elopement evaluations are completed as required for one of seven residents (Resident R1), and that each resident received adequate supervision that resulted in an elopement for one of two residents (Resident R1). Findings include: Review of facility policy Elopement Risk Assessment last reviewed 8/30/23, indicated that residents will be assessed for elopement risk on admission, quarterly, and as needed with significant changes. Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of Resident 1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 6/12/24, indicated diagnoses of dementia (neuro-cognitive disorder impacting reasoning, judgment, and memory), bradycardia (slow heart rate), and anxiety (a feeling of worry, nervousness, or unease). Review of Resident R1 ' s Admission Nursing Comprehensive Data Collection dated 5/24/24 indicated that Resident R1 was evaluated for an Elopement Risk and received a score of 1, which indicated that resident is Not currently at risk for elopement behavior. Re-evaluate as required. Review of clinical record revealed a nursing progress note dated 5/24/24, that stated Resident R1 required frequent redirection and constant monitoring by dinner time, still alert to self and unable to comprehend what was being said. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of documentation provided by the facility stated that on 5/27/24, Resident R1 had exited out the back door of the unit, Resident pushed back door open and proceeded outside with Wanderguard (a monitoring device worn on the wrist or ankle that alerts staff when a resident leaves a safe area) bracelet intact. Resident R1 saw a family member of another resident and asked for a ride home. He was escorted back to the front entrance by that family member and returned within minutes. Resident was observed on cameras exiting the building at 2:56 p.m He was observed being brought back in the building at 2:58 p.m.at which time nursing was alerted and the Wanderguard at the front entrance alarmed. The set of doors that the resident used to exit the building are locked at all times and set up to open when a fire alarm is set off, There is also a Wanderguard reader at those doors in case someone were to follow a staff member out. Staff educated that they must carry RCare phones (a portable alert system) so that they receive immediate notification of door opening in the event of another malfunction. Door technician performed maintenance on the door in question. Door was found to have malfunctioned when resident approached it. (Causing the door to open in the presence of a Wanderguard as opposed to locking it) Door is now reset to function appropriately and maintenance is performing daily checks on all Wanderguard alarms. All staff are being re-educated on elopements. Resident R1 was assessed as an elopement risk on admission and a Wanderguard placed at the time. Residents are assessed for elopement risk/exit seeking behavior on admission, quarterly, and with significant change. Maintenance performs checks on doors monthly to ensure they are latching appropriately. Maintenance receives alarms from the system if a door is not functioning correctly. In this instance, the door was functioning per its programming and would not have alarmed. The programming was entered incorrectly by the door alarm company. It has been confirmed with them that all doors on the system are now programmed correctly (to lock when a Wanderguard is detected). Maintenance is now performing daily checks on all Wanderguard doors and will continue those for two weeks, and then weekly going forward. Review of a written Employee Witness statement dated 6/2/24, indicated that Nurse Aide Employee E10 had last seen Resident R1 at 2:30 p.m. when she provided him with a shower. During a tour of the facility on 6/18/24, at 10:15 a.m. State Agency was unable to exit the door that Resident R1 had egressed from as it was locked, and had a keypad that required a code be entered to leave via this door. Review of clinical record did not reveal any documentation that resident had exhibited any wandering behaviors after 5/24/24 admission note, or that he was placed on a Wanderguard. During an interview on 6/18/24, at 11:20 a.m. Director of Nursing (DON)stated that the Nursing Supervisor had called her at home on Sunday 5/26/24, and expressed concern that Resident R1 may try to leave the unit. DON instructed her to place a Wanderguard on Resident R1 for safety. DON confirmed that there was not any documentation regarding wandering behavior or that staff had applied a Wanderguard. During an interview on 6/18/2024, 11:34 a.m. Maintenance Director (MD) Employee E7 stated that Wanderguard audits are new, and when he was asked by State Agency if any monitoring of the doors had been done prior to the elopement on 5/27/24, MD Employee E7 replied No, which is strange., and that he only completed them with the door alarm company when they would come into the building for maintenance, and were completed in the presence of the door alarm company. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of invoices from the door alarm company indicated that services were provided on 9/21/23, 1/12/24, 2/15/24, and 5/30/24. During an interview on 6/18/24, at 12:11 p.m. Registered Nurse (RN) Employee E4 stated that she was present on the day of Resident R1's elopement. RN Employee E4 explained that she admitted Resident R1 on Friday 5/24/24, and found him not be an elopement risk. She was then off on Saturday and Sunday (5/25/24, and 5/26/24). When RN Employee E4 came back to work on Monday 5/27/24, Resident R1 had a Wanderguard. RN Employee E4 stated that Resident R1 had not exhibited any wandering behaviors that day prior to his elopement. RN Employee E4 stated that she was at the nurses station at the time of the elopement and that there is a monitor at the desk that would alert them if someone had tried to leave out of the door with a Wanderguard, however the alarm did not go off and she also did not hear the door close which typically bangs when it is closed. She did hear the alarm when Resident R1 was brought back into the building by a visitor as the front door was working properly in regards to the Wanderguard system. Review of clinical record did not reveal any documentation that Resident R1 had been re-assessed for an elopement risk after his elopement. During an interview on 6/18/24, at 12:17 p.m. Associate Director Employee E9 confirmed that the facility failed to complete a new elopement evaluation for Resident R1 after his elopement. During an interview on 6/18/24, at 4:08 p.m., Nursing Home Administrator confirmed that the facility failed to make certain that elopement evaluations are completed as required and that each resident received adequate supervision that resulted in an elopement. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.