

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Cornwall Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  Boyd Street Cornwall, PA 17016	
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 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>43883</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide behavioral health services for one of three sampled residents with mood and behavior concerns. (Resident 22)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 22 had diagnoses that included anxiety. Review of the care plan revealed the resident had a history of suicidal ideation and alterations to psychosocial well-being with behaviors and delusions. The interventions were for staff to monitor the resident for anxiety, distress, and changed mood or behavior. Staff were to notify the resident's physician, provide social services case assistance, and interventions as needed. On July 26, 2024, staff noted that the resident had refused to go to bed or allow staff to provide incontinence care and stated that she just wanted to die. There was no evidence that staff notified social services or the resident's physician of the alteration in the resident's mood.</p> <p>In an interview on August 1, 2024, at 9: 49 a.m., the Director of Nursing confirmed that staff were to notify social services or the physician for changes in mood and there was no evidence that the resident's care team was made aware of the alteration in mood or that interventions were implemented.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</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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