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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER: Laurel Ridge Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 75 Hickle Street, Uniontown, PA 15401	

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 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** 39311 Based on review of facility policy and documents, clinical records, and staff interview, it was determined that the facility failed to make certain a resident was free from the use of a physical restraint without a physician's order for one of three residents reviewed (Resident R1). Findings include: Review of facility policy Abuse Prohibition, reviewed 6/3/24, revealed that the facility prohibits abuse, mistreatment, neglect, misappropriation of property, and exploitation. This includes freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. Review of the facility policy, Restraints: Use of reviewed 6/3/24, indicated a physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: -Is attached or adjacent to the patient's body, -Cannot be removed easily by the patient, and -Restricts the patient's freedom of movement or normal access to their body. The policy further stated that there must be documentation identifying the medical symptom being treated and an order for the use of the specific type of restraint. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2023, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record indicated Resident R1 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Minimum Data Set (MDS - federally mandated assessment of a resident's abilities and care needs) dated 8/5/24, included diagnoses of Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking) and a leg/hip fracture. Review of Section C: Cognitive Patterns, Questions C0500 BIMS Summary Score revealed Resident R1's score to be 5. Review of Resident R1's plan of care for behavior management, initiated 8/4/24, indicated the goal for Resident R1 to remain safe while in the facility. Review of a progress note written by Registered Nurse (RN) Employee E2 on 8/17/24, at 11:58 a.m. stated Received concern that resident had gait belt applied last weekend on 8/11/24 to torso. Resident assessed at this time for any injuries or negative outcomes from use of device to which none were noted on assessment. Resident has no change in demeanor nor does he demonstrate any fears or fearfulness. Review of documentation submitted by the facility on 8/17/24, revealed After receiving notice of allegation on August 17, 2024. The Director of Nursing started an investigation and statements obtained. The nurse [RN Employee E1] immediately suspended pending investigation. Adult Protective Services (APS) was notified, and spoke to an employee from APS. The Family of resident involved was notified of the incident as well as [attending provider]. Head to toe assessments including skin and pain completed on residents. Resident placed on User Defined Assessment (UDA) for change in condition. Resident has BIMS 5 and a history of repeated falls. Preventive measure for falls in place. Resident ambulates with 2 assists. The resident was last by CNA (NA - nurse aide) at meal time. The care plan was reviewed. Education provided to all nurses regarding the policy for Abuse, Neglect and restraints. All staff on hire are educated on abuse, neglect and restraints annually. Update (8/20/24): The RN did use a gait belt as a restraint. The gait belt was used to tie resident to chair. The resident was assessed for injury. The RN assessed the resident and he did not have any injury from the incident. The staff was educated immediately on Abuse, Neglect and restraints. The resident will be monitored closely and brought to the nurses station when needed for one on one. Review of a facility investigation statement dated 8/17/24, written by RN Employee E1 stated, Incident really started day prior when resident fell from low bed three times in two hours. This resident with Parkinson's with delusions and hallucinations No safety awareness recovering from a hip fracture he had sustained on a previous incident in our facility. Now with Covid. Had already failed all attempts by Occupational Therapy (OT) for any safe positioning device gerichair, wheelchair with dropseat, reclining wheelchair, pommel cushion as he kept sliding out of chair during trials in therapy. On Sunday so rigid from being flat in bed that initially he was unable to bend at waist to sit up for feeding. Did passive range of motion gaining some bend at waist with mechanical lift placed in gerichair where he once again assumed rigid posturing sliding out foot of chair. Unfortunately, we do not have enough staff to one on one which is what he really needed; Asked OT what to do. No suggestions Talked to son describing the dilemma that I did not know how to keep his father safe with his confusion, restlessness, unsteady gait and recent falls did discuss lap buddy explaining it would go between the arm of wheelchair to which he agreed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/24, at approximately 1:40 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that facility failed to make certain a resident was free from the use of a physical restraint without a physician's order for one of three residents reviewed. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.20(a)(b) Staff development. 28 Pa. Code 201.29(a)(c)(d) Resident rights.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39311 Based on review of state laws, facility documents, clinical records, and staff interviews, it was determined that the facility failed to implement policies and procedures for covered individuals to report the suspicion and/or observation of possible abuse for one of three residents (Resident R1). Findings include: Review of the Older Adult Protective Services Act of 11/6/87, amended by Act 1997-13, Chapter 7, Section 701, requires any employee or administrator of a facility who suspects abuse is mandated to report the abuse. All reports of abuse should be reported to the local area agency on aging and licensing agencies. Review of facility policy Abuse Prohibition, reviewed 6/3/24, revealed that the facility prohibits abuse, mistreatment, neglect, misappropriation of property, and exploitation. This includes freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. The policy further stated that anyone who witnesses an incident of suspected abuse is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of shift worked. Review of the facility policy, Restraints: Use of reviewed 6/3/24, indicated a physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: -Is attached or adjacent to the patient's body, -Cannot be removed easily by the patient, and -Restricts the patient's freedom of movement or normal access to their body. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2023, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record indicated Resident R1 was originally admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS, federally mandated assessment of a resident's abilities and care needs) dated 8/5/24, included diagnoses of Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking) and a leg/hip fracture. Review of Section C: Cognitive Patterns, Questions C0500 BIMS Summary Score revealed Resident R1's score to be 5. Review of Resident R1's plan of care for behavior management, initiated 8/4/24, indicated the goal for Resident R1 to remain safe while in the facility. Review of a progress note written by Registered Nurse (RN) Employee E2 on 8/17/24, at 11:58 a.m. stated Received concern that resident had gait belt applied last weekend on 8/11/24 to torso. Resident assessed at this time for any injuries or negative outcomes from use of device to which none were noted on assessment. Resident has no change in demeanor nor does he demonstrate any fears or fearfulness. Review of documentation submitted by the facility on 8/17/24, revealed After receiving notice of allegation on August 17, 2024. The Director of Nursing started an investigation and statements obtained. The nurse [RN Employee E1] immediately suspended pending investigation. Adult Protective Services (APS) was notified, and spoke to an employee from APS. The Family of resident's involved was notified of the incident as well as [attending provider]. Head to toe assessments including skin and pain completed on residents. Resident placed on User Defined Assessment (UDA) for change in condition. Resident has BIMS 5 and a history of repeated falls. Preventive measure for falls in place. Resident ambulates with 2 assists. The resident was last by CNA (NA, nurse aide) at meal time. The Care plan was reviewed. Education provided to all nurses regarding the policy for Abuse, Neglect and restraints. All staff on hire are educated on abuse, neglect and restraints annually. Update (8/20/24): The RN did use a gait belt as a restraint. The gait belt was used to tie resident to chair. The resident was assessed for injury. The RN assessed the resident and he did not have any injury from the incident. The staff was educated immediately on Abuse, Neglect and restraints. The resident will be monitored closely and brought to the nurses station when needed for one on one. Review of a facility investigation witness statement dated 8/19/24, written by NA Employee E3 stated, August 11, 2024 I went on C hall to help pass trays and a CNA told me [Resident R1] was gaitbelt to wheelchair and I want back an looked, and came out and asked if [RN Employee E1] was aware and they said yes, because [RN Employee E1] did it. NA Employee E3 answered, Did you previously report the event or injury? (if yes, to whom did your report?) as Yes to the aide that worked c-hall and he said [RN Employee E1] was aware because [RN Employee E1] did it. Review of a facility investigation witness statement dated 8/19/24, written by NA Employee E4 stated, I was assigned to the hall and they stated that they were finding a chair buddy and [RN Employee E1] had put the gait belt around him to prevent him falling. At the time I was really busy and didn't stop to think. NA Employee E4 did not answer the question, Did you previously report the event or injury? (if yes, to whom did your report?). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility investigation witness statement dated 8/17/24, written by Licensed Practical Nurse (LPN) Employee E5 stated, On Sunday, RN charge nurse [RN Employee E1] obtained a gait belt from the therapy department. This gait belt was used to secure resident in [room number] in a chair. I did not witness the gait belt around the resident but the RN charge nurse did state that she placed it around him to keep him from sliding out of the chair. I was the nurse on skilled hall on 8-11-24. The resident was not in my care. LPN Employee E5 answered, Did you previously report the event or injury? (if yes, to whom did your report?) as No. Review of a facility investigation witness statement dated 8/19/24, written by NA Employee E6 indicated on 8/10/24, [Resident R1] had his light on I walked in the room and seen he was tied to the chair with a gait belt. He was was sliding out the chair so [LPN Employee E5] asked me to help pull him back up. NA Employee E6 answered, Did you previously report the event or injury? (if yes, to whom did your report?) as No. Review of a facility investigation witness statement dated 8/16/24, written by NA Employee E7 stated, I saw [Resident R1] on the floor, not on Sunday morning. Peers explained he was sitting on the [NAME] (geri) chair, strapped with a gait belt. Chair & gait belt were still in place from a couple hours earlier. NA Employee E7 answered, Did you previously report the event or injury? (if yes, to whom did your report?) as Yes with no name as to who it was reported to. Review of a facility investigation witness statement dated 8/17/24, written by NA Employee E8 stated, Did not witness but heard about. NA Employee E8 did not answer the question, Did you previously report the event or injury? (if yes, to whom did your report?). During an interview on 8/27/24, at approximately 1:40 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that facility failed to implement policies and procedures for covered individuals to report the suspicion and/or observation of possible abuse for one of three residents. 28 Pa. Code 201.14(a)(c)(e) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.18(e)(1) Management.