STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395243	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Ridge Center	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 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** 31343 Based on review of facility policy, facility documentation, and staff interviews, it was determined that the facility failed to protect residents from neglect for one of two residents (Resident R12), by failing to follow physicians orders during transfer from a wheelchair into bed. This was identified as past non-compliance. Findings include: Review of the United States Code of Federal Regulations (CFR), 42 CFR S483.12. Freedom from Abuse, Neglect, and Exploitation defined neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Review of the facility policy Abuse Prohibition last reviewed on 6/3/24, with a previous reivew date of 11/1/23, indicated that the center staff are doing all that is within their control to prevent occurrences of abuse, neglect, etc. The center must ensure that all staff are aware of reporting requirements. The investigation will be completed within 24 hours, the center will protect residents from further harm during the investigation, corrective action will be taken depending on the results of the investigation. Review of the clinical record indicated that Resident R12 was admitted to the facility on [DATE], with diagnoses which included kidney disease, bladder dysfunction, adult failure to thrive, chronic pain and sacral pressure ulcer. An MDS (Minimum Data Set- a periodic assessment of resident care needs) dated 5/21/24, indicated the diagnoses remained current. Review of Resident R12's plan of care dated 5/24/24, indicated that Resident R12 was an extensive assist of two for transfers with use of a total lift. Review of an incident report dated 11/18/23, indicated that Resident R12 had told Registered Nurse(RN) Employee E1 that she had been transferred from her wheelchair to bed without use of the lift by Nurse Aide(NA) Employee E2 and NA Employee E3 which resulted in pain of her right lower extremity. Resident R12 stated that the identified Nurse Aides had worked the evening shift. Resident R12 was assessed by RN Employee E1 with identified pain ranked as a ten of ten with right ankle bruising and Resident R12's right leg internally rotated. The Medical Director and family were notified. Resident R12 initially refused to go to the hospital but did transfer later. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a statement dated 11/18/23, obtained from Resident R12's roommate Resident R300 indicated that she had overheard staff talking but could not identify what they said but that she knows that staff had transferred Resident R12 the previous week without use of the lift. Review of a statement dated 11/18/23, from NA Employee E3 indicated that on 11/17/23, she had identified that a lift pad was not underneath Resident R12 when she and NA Employee E2 had transferred Resident R12, they lifted her and put Resident R12 into bed, at the time Resident R12 did not indicated any pain but later did and NA Employee E3 told the RN on shift. Review of a witness statement dated 11/18/23, from NA Employee E2 indicated that on 11/17/23, she and NA Employee E3 had to put Resident R12 into bed as Resident R12 was not feeling well and was in pain. NA Employee E2 indicated that a sling pad was not under Resident R12 and NA Employee E2 indicated Resident R12 was assist of two and they put her into bed, and provided incontinence care. NA Employee E2 stated that by the time she and NA Employee E3 started second rounds, Resident R12 stated she was having right leg pain and she and NA Employee E3 went to get the RN. During an interview on 7/10/24, at 3:00 p.m. NA Employees E2 and E3 reiterated their statements and stated afterwards they asked the previous shift staff why Resident R12 did not have a sling pad under her in the chair and the staff stated they used a split pad NA Employee E2 stated that Resident R12 would never have let them use a split pad as they hurt her thighs and private areas. NA Employee E2 stated that they did not know why they were the only two suspended. Review of the disciplinary actions for NA Employee E2 and NA Employee E3 indicated suspension until the investigation was completed, they were provided re-training on lift use and use of the kardex/care plan. Review of the facility plan of correction dated 11/20/23, indicated a review of all resident transfers with identification of resident's requiring lifts, pads used and making certain each resident had the pads available for use. Review of the facility plan of correction dated from 11/18/23, thorough 11/20/23, indicated a nursing staff re-education related to review of care plan/kardex and use of following resident orders for transfer. During an interview on 7/10/24, at 2:10 p.m., the Director of Nursing and Administrator confirmed that the facility failed to protect residents from neglect for one of two residents (Resident R12), by failing to follow physicians orders during transfer from a wheelchair into bed. The facility has demonstrated compliance with the regulation since 11/20/23. During an interview on 7/10/24, at 2:10 p. m., with the Nursing Home Administrator and Director of Nursing, and review of the facility's immediate actions, education, and review of the QAPI monitoring process to sustain solutions, it was verified that the facility had implemented a plan of correction and achieved compliance ensuring the prevention of resident neglect. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.20(b)(1) Staff Development. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.11(d) Resident care plan. 28 Pa Code 211.12(d)(1)(2)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49646 Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels and failed to assess residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood glucose), for three of seven Residents (Residents R5, R30, R37). Findings: Review of the clinical record revealed Resident R5 was admitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and anxiety. Review of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 5/1/24, indicated the diagnoses remain current. Review of a physician order dated 5/29/24, revealed Novolog (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) insulin, 7 units once a day, if greater than 350 move to a medium scale two times a day. On 7/1/24, Lantus (long-acting type of insulin that works slowly, over about 24 hours), 37 units once daily. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 5/8/24, at 4:24 p.m. CBG was noted to be 41. On 5/25/24, at 4:48 p.m. CBG was noted to be 52. On 6/1/24, at 4:47 p.m. CBG was noted to be 67. On 6/2/24, at 5:58 a.m. CBG was noted to be 63. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hypoglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of the care plan dated 5/22/24, included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, monitor/document/report to MD as needed for signs and symptoms of hypo-/hyperglycemia. Review of the clinical record revealed Resident R30 was admitted to the facility on [DATE], with diagnoses that included diabetes, end-stage renal disease (kidneys lose the ability to remove waste and balance fluids), muscle weakness. Review of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 6/5/24, indicated the diagnoses remain current. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 6/24/24, revealed Humalog insulin, 2 units three times a day, Humalog sliding scale with result greater than 450 give additional 14 units. A physician order dated 3/20/23, revealed Lantus 22 units daily. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 7/3/24, 6:20 a.m. CBG was noted to be 407. On 7/3/24, 4:10 p.m. CBG was noted to be 61. On 7/6/24, 6:18 a.m. CBG was noted to be 400. On 7/10/24, 6:12 a.m. CBG was noted to be 477. On 7/11/24, 6:23 p.m. CBG was noted to be 67. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of the care plan dated 3/29/23, 5/9/23, and 6/24/24, included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, monitor/document/report to MD as needed for signs and symptoms of hypo-/hyperglycemia. Review of the clinical record revealed Resident R37 was admitted to the facility on [DATE], with diagnoses that included diabetes, muscle weakness and chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe). Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of a physician order dated 5/15/24, indicated to inject Novolog insulin per sliding scale, if over 400 give 10 units, call physician if greater than 450. A physician order dated 1/19/24, revealed Lantus 18 units daily. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 5/23/24, at 6:36 a.m. CBG was noted to be 69. On 6/3/24, at 6:48 a.m. CBG was noted to be 70. On 6/14/24, at 8:00 p.m. CBG was noted to be 402. On 6/15/24, at 6:20 a.m. CBG was noted to be 61. On 6/15/24, at 4:20 p.m. CBG was noted to be 412. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/24, at 11:56 a.m. CBG was noted to be 468. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, failed to follow physician ' s order, and the physician was not notified of abnormal results on the above listed dates. Review of the care plan dated 5/22/24, included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, monitor/document/report to MD as needed signs and symptoms of hypo-/hyperglycemia. During an interview on 7/11/24, at approximately 8:30 a.m. Licensed Practical Nurse (LPN) Employee E4 stated for residents without diabetic parameters they would notify the doctor for blood glucose levels under 70, assess if unresponsive give Glucagon (medicine to increase blood sugar), if responsive give glucose gel, or over 450, give insulin per order, call doctor and document in progress notes. During an interview on 7/12/24, at 9:10 a.m. LPN Employee E5 stated for residents without ordered diabetic parameters they would notify the doctor if blood glucose was under 70, or over 450. They would follow facility protocol for low results, and if it was high, they would give the ordered insulin and notify the charge nurse for either level parameter. During an interview on 7/12/24, at 9:16 a.m. LPN Employee E6 stated for residents with ordered parameters of blood glucose results were under 70, or over 450, they would follow facility protocol. If it was low, they would start the facility protocol, call the doctor and the RN (registered nurse) supervisor, and recheck the blood glucose in 15 minutes. They would document the incident in the progress notes and the eMAR. During an interview on 7/12/24, at 9:15 a.m. the Director of Nursing (DON) confirmed the facility failed to provide timely and complete communication to a physician when there was a change in condition. The DON confirmed the facility failed to recognize, assist and document the treatment of complications commonly associated with diabetes. Documentation should reflect the carefully assessed diabetic resident for vital signs, skin (color, temperature, dryness, sweating, irritation or abrasions), percentage of meals consumed, mood changes, pain, restlessness, numbness/tingling, results of any fingerstick, interventions to stabilize the blood glucose levels and response, notification of physician of unstable or significant variances from base line per physician order. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 201.29(d) Resident rights. 28 Pa. Code: 211.10 (c)(d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.