STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Autumn Grove Care Center	555 South Main Street Harrisville, PA 16038

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of clinical records, observations, and staff interviews, it was determined that the facility failed provide an environment that enhances resident's quality of life for three of 21 residents reviewed (Residents R25, R65, R69). Findings include: Resident R25's clinical record revealed an admitted [DATE], with diagnoses that included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), dementia, tremors, need for assistance with personal care, and cognitive communication deficit (communication difficulty that is caused by a cognitive deficit rather than a language or speech deficit). The clinical record lacked evidence of a physician's order and/or plan of care to address him/her consuming meals while sitting in the hall at the nurse's station. Resident R25's most recent Admission/5-Day Minimum Data Set (MDS-standardized assessment tool used to evaluate the health and functional abilities of residents in Medicare or Medicaid certified nursing homes) Section C0500 with an Assessment Reference Date (ARD-a time period to look back for review of resident status) of 6/19/24, indicated that Resident R25's Brief Interview of Mental Status (BIMS-cognitive screening tool used in nursing homes and other long-term care facilities to assess the cognitive condition of residents) score of four (severely impaired cognition). Resident R65's clinical record revealed an admitted [DATE], with diagnoses that included dementia, anxiety, mood disorder, and difficulty eating. The clinical record lacked evidence of a physician's order and/or plan of care to address him/her consuming meals while sitting in the hall at the nurse's station. Resident R65's most recent Significant Change MDS Section C0500 with an ARD of 8/15/24, indicated that his/her BIMS score was a score of one (severely impaired cognition). (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R69's clinical record revealed an admitted [DATE], with diagnoses that included psychotic disorder, Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills, and eventually the ability to perform even the simplest tasks), anxiety, and cognitive communication deficit. The clinical record lacked evidence of a physician's order and/or plan of care to address him/her consuming meals while sitting in the hall at the nurse's station. Resident R69's most recent Quarterly MDS Section C0500 with an ARD of 7/03/24, indicated that his/her BIMS score was a score of three (severely impaired). Observations on 8/22/24, at 12:49 p.m. revealed Residents R65 and R69 feeding themselves lunch at a tray table while sitting in the hall across from the Unit C/D nurse's station, and Resident R25 being fed by staff at a tray table while sitting in the hall across from the Unit C/D nurse's station. During an interview at that time, Registered Nurse Employee E2 confirmed the main dining area is at max capacity so residents eat here, those who cannot eat in their rooms have to eat up here, the resident lounge is not open during meals due to the choking incident. During an interview on 8/23/24, at 10:10 a.m. the Executive Director and Nursing Home Administrator confirmed that there is not enough room for all residents to eat in the main dining area at one time. 28 Pa. Code 205.9(c) Corridors 28 Pa. Code 201.18 (b)(3) Management 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.10 (a) Resident Care Policies 28 Pa. Code 211.12 (d)(1)(5) Nursing Services

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31185 Based on review of clinical records and Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), and staff interview, it was determined that the facility failed to ensure that MDS assessments accurately reflected the status of two of 21 residents reviewed (Residents R15 and R32). Findings include: MDS instructions for section N0350A Medications - Insulin Injections revealed to Record the number of days that insulin injections were received during the last 7 days or since admission / entry or reentry if less than 7 days. Resident R15's clinical record revealed an admitted [DATE], with diagnoses that included Type II diabetes (condition that affects how your body uses insulin), breast cancer, and dementia (loss of cognitive functioning affecting a persons memory and behaviors). Resident R15's clinical record revealed a physician's order dated 4/12/24, for Liraglutide injection (an antihyperglycemic [medication to reduce elevated blood sugar levels] injection used to help control blood sugar, which is not classified as an insulin) 1.8 milligrams (mg) one time a day. Further review of Resident R15's clinical record revealed a physician's order dated 4/26/24, for Trulicity injection (an antihyperglycemic injection used to help control blood sugar, which is not classified as an insulin) 1.5 mg every Friday. Resident R15's admission MDS with an Assessment Reference Date (ARD-time period to look back to review resident status) of 4/18/24, indicated Resident R15 received insulin six of the last seven days. Resident R15's quarterly MDS with an ARD of 5/30/24, indicated that Resident R15 received insulin one of the last seven days. Resident R32's clinical record revealed an admitted [DATE], with diagnoses that included morbid obesity, heart failure and hyperglycemia (elevated blood sugar level). Resident R32's clinical record revealed a physician's order dated 5/30/24, for Trulicity injection 1.5 mg every Thursday. Resident R32's quarterly MDS with an ARD of 7/16/24, indicated that Resident R32 received insulin one of the last seven days During an interview on 8/22/24, at 2:09 p.m. the Registered Nurse Assessment Coordinator confirmed that neither Liraglutide or Trulicity are classified as insulin and Resident R15's and R32's MDS's for section N0350A were coded incorrectly and should have been coded as zero. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f)(ix) Medical records

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to maintain proper care of respiratory equipment for one of two residents reviewed for respiratory services (Resident R66). Findings include: Review of facility policy dated 8/7/24, entitled Oxygen Concentrators indicated The facility will include cleaning of humidifiers and filters to maintain optimal function and infection control procedures and for filters clean weekly and as needed, rinse thoroughly with clear water, and towel day to remove excess water. Resident R66's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD - a lung disease that results in difficulty breathing, cough, and mucus production), dementia (loss of cognitive functioning affecting a persons memory and behaviors), and high blood pressure. Resident R66's physician's order dated 2/27/24, revealed that oxygen was ordered at three liters per minute every shift via nasal cannula (tubing that enters into the nostrils to administer oxygen). Further review of physician orders revealed that the oxygen filter is to be cleaned weekly every night shift every Sunday. Observation on 8/20/24, at approximately 12:13 p.m. and on 8/21/24, at approximately 8:52 a.m. revealed that Resident R66's oxygen concentrator had one filter on the back of the concentrator that contained a gray dusty substance. During an interview on 8/21/24, at approximately 8:55 a.m. Licensed Practical Nurse Employee E1 confirmed that the oxygen concentrator filter contained a gray dusty substance and should not. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility dialysis (a blood purifying treatment given when your kidneys are not functioning) center contract, facility policy, and clinical record, and staff interview, it was determined that the facility failed to maintain records relating to dialysis communication for one of one residents reviewed for dialysis (Resident R79). Findings include: Review of dialysis contract between the facility and the dialysis clinic dated 7/18/14, revealed that the responsibility of the skilled nursing facility included that the healthcare staff will make an assessment of each patient's physical condition and determine whether the patient is stable enough to be dialyzed on an outpatient basis. If it is determined that a patient is sufficiently stable, this assessment will be communicated to the facility's nurse manager or his or her designee. This assessment and communication will occur prior to each and every transfer of a patient to the dialysis clinic for hemodialysis on an outpatient basis regardless of the number of times any particular patient may be transferred and dialyzed. The agreement further stated that the dialysis clinic shall provide to the facility information which may be utilized in the development and maintenance of the patients care plan and information about how care should be rendered to a patient in emergency and non-emergency situations. Review of facility policy dated 8/7/24, entitled Dialysis indicated It is the policy of this facility to maintain medical record documentation for residents receiving renal dialysis in accordance with state and federal regulations and regulatory guidelines. The policy further stated The renal dialysis provider will provide the facility with copies of reports of all tests performed on the resident during renal dialysis, written physician orders or recommendations for change in medications/treatment and a copy of reports of any unusual events occurring while at the dialysis unit. The reports will be returned with the resident following each treatment. And Should the renal dialysis unit fail to comply with this agreement, the Charge Nurse will notify the facility Administrator who will in turn contact the Administrative Officer in charge of the renal dialysis unit. Resident R79's clinical record revealed an admitted [DATE], with diagnoses that included end stage renal disease (a disease where the kidneys no longer work to meet the body's needs), diabetes, and anxiety. Review of R79's physician orders dated 5/9/24, revealed Resident R79 received dialysis every Monday, Wednesday, and Friday with a chair time of 6:30 a.m. On 8/22/24, at approximately 3:35 p.m. it was requested for evidence that communication between the facility and the dialysis center was occurring with each dialysis treatment every Monday, Wednesday, and Friday for Resident R79. Upon review of dialysis communication documents dated between 5/31/24, and 7/15/24, it was identified that there was no evidence that any evidence of communication was provided by the facility to the dialysis center since 7/15/24, for a total of 16 visits to the dialysis center from 7/15/24, to 8/22/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/23/24, at 10:42 a.m. the Executive Director confirmed the lack of communication from the facility to the dialysis center for Resident R79 since 7/15/24, and additionally confirmed that communication is to occur between the facility and the dialysis center for each treatment rendered and the facility should have evidence of this in the resident's clinical record. 28 Pa. Code 211.5(f)(iv)(viii) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store food and food containers in a safe and sanitary manner in two of two nourishment refrigerators (A/B Unit, C/D/Unit). Findings include: A facility policy entitled, Food Safety for your Loved One dated 8/07/24, indicated food or beverages should be labeled and dated to monitor for food safety: food and beverages that have passed the manufacturer's expiration date will be discarded; food or beverage items without an manufacturer's expiration date should be dated upon arrival in the facility and thrown away seven days after the date marked; and foods in unmarked or unlabeled containers should be marked with the current date the food item was stored and the resident's name. A facility policy entitled, Food Brought in from Outside Sources and Personal Food Storage dated 8/07/24, indicated that foods and beverages brought in from outside sources that require refrigeration or freezing should be labeled with the resident's name and date. A facility policy entitled, Food Availability dated 8/07/24, indicated that food and nutrition services staff are responsible for cleaning and sanitizing refrigerators on a regular cleaning schedule and as needed. Observation on 8/23/24, at 10:40 a.m. of the pantry refrigerator on the A/B Unit revealed the following food items without a resident name or date: a clear plastic container half full and labeled as ham salad; a white plastic bowl covered with aluminum foil and half full of a rice and corn mixture; a red [NAME] bag that contained a clear plastic wrapping of deli meat and cheese, and a clear plastic container of fresh cut vegetables with a best if used by date of 8/16/24. Observation on 8/23/24, at 10:53 a.m. of the pantry refrigerator on the C/D Unit revealed: a white foam container with chicken tenders and a pint size Chinese take-out container with someone's first name on it and dated 8/07/24. Also in the refrigerator were the following items that lacked a name and date: three pizza boxes that contained various slices of pizza, a black plastic container with a clear lid that contained a piece of meat, one submarine sandwich and a croissant in a cooler bag, black lunch pail that contained two cans of Mountain Dew and a sandwich, and a 3/4 full clear plastic drink cup of dark colored pop with a straw. The shelves and bottom of the refrigerator had dried spills of a variety of colored liquids, food crumbs and debris. During an interview on 8/23/24, during the above observations the Dietary Manager confirmed that the refrigerators on both units contained outdated, unlabeled, and undated food items and the refrigerator of C/D Unit contained the dried spills, food crumbs, and debris. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 201.18(b)(1) Management