

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Shadyside Skilled Nursing and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  5609 Fifth Avenue Pittsburgh, PA 15232	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>46337</p> <p>Based on observation, review of facility documentation, resident and staff interviews it was determined that the facility failed to provide a dignified dining experience for meals for one of three units (4th Floor Nursing Unit).</p> <p>Findings include:</p> <p>Review of the facility policy FNS308 Meal Service dated 5/7/24, indicated meals are served accurately, timely, and at the appropriate temperature. It was indicated bases and dinner plates are heated for hot meals. The only exception to the use of disposable dishes are if the dishwasher is broken, or the resident is on suicide precautions.</p> <p>Review of the facility policy NSG270 Meal Service dated 5/7/24, indicated it is the policy of the facility to provide safe, sanitary, and dignified meals services which account for patient preference.</p> <p>Review of a grievance form dated 3/7/24, indicated meals are still coming up at times in Styrofoam containers/bowls. Plastic silverware is sent up, and at times no knife is provided.</p> <p>Review of a grievance form dated 7/11/24, indicated Styrofoam is still being used during meals.</p> <p>Review of the facility's food committee minutes dated 7/11/24, indicated a concern for Styrofoam still being used during some meals.</p> <p>During an observation on 7/22/24, at 9:10 a.m. Resident R47, R122, and R24 received their breakfast served in a Styrofoam container.</p> <p>During an interview on 7/22/24, at 9:11 a.m. Nurse Aide (NA) Employee E21 confirmed Styrofoam containers were being used to serve breakfast for residents. NA Employee E21 stated sometimes the end of the hallway will get Styrofoam. Not sure if they run out or something. NA Employee E21 confirmed the facility failed to provide residents with a dignified dining experience.</p> <p>(continued on next page)</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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/22/24, a 11:20 a.m. Dietary Aide Employee E13 stated, Styrofoam was used for breakfast on the 4th floor as we ran out of plates. Dietary Aide, Employee E13 confirmed the facility failed to provide residents with a dignified dining experience for one of three nursing units (fourth floor).</p> <p>PA Code: 201.29(j) Resident Rights</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>49469</p> <p>Based on review of facility policy, observations, resident council group interview, and resident and staff interviews, it was determined that the facility failed to have an ample linen supply at the staff's immediate use on two of three units (second floor and third floor).</p> <p>Findings include:</p> <p>Review of the facility Accommodation of Needs policy dated 5/7/24, indicated the resident/patient (hereinafter patient) has the right to a safe, clean, comfortable, and homelike environment including, but not limited to, receiving treatment and support for daily living safely. The Center must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior including but not limited to clean bed and bath linens that are in good condition.</p> <p>During an interview 7/22/24, at 8:35 a.m. Resident R101 stated, There were no washcloths or towels last Thursday 7/18/24, the aide had to use paper towels to clean me up.</p> <p>During an interview 7/22/24, at 8:45 a.m. Resident R26 stated, Sometimes I have to wait for care as there are no washcloths or towels available.</p> <p>During an interview on 7/22/24, at 8:57 a.m. Registered Nurse (RN) Employee E8 stated, The aides complain that there is not enough linens, residents also complain that linen carts are not on the floor, all linen is kept in the second floor linen room across from nursing station.</p> <p>During an observation on 7/22/24, at 9:00 a.m. the second-floor linen room revealed barren linen supplies containing one towel and twelve washcloths.</p> <p>During an interview on 7/22/24, at 9:00 a.m. RN Employee E8 confirmed the linen room was barren in linen supplies having only one towel and twelve washcloths available.</p> <p>During Resident Council (a meeting held with residents) on 7/23/24, at 10:02 a.m. five out of eight residents agreed and stated, There is not enough towels and wash towels. The facility doesn't get wipes anymore, they use wash towels for incontinent care or anything they can get their hands on. We don't have enough wash towels and bath towels.</p> <p>During an observation on 7/23/24, at 10:33 a.m. the second-floor linen room revealed barren linen supplies containing no towels of washcloths.</p> <p>During an interview on 7/23/24, at 10:33 a.m. RN Employee E1 confirmed the linen room was barren in linen supplies containing no towels or washcloths and state, The linen supply is hit or miss, you can call the other floors as it is shared, it is an issue.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/24/24, at 12:26 p.m. RN Employee E17 stated, Linens run out all of the time. There are no linens to make beds for new admissions. They have to wait in the hallway for 20 minutes while we run around and go to other floors to find linens to make up their bed. We run out of washcloths and towels all the time, we've had to clean residents with paper towels multiple times because there are not enough linens.</p> <p>During an observation on 7/24/24, at 1:19 the third-floor high linen room had four blankets, four pillow cases, seven flat sheets, no wash towels, and no bath towels.</p> <p>During an interview on 7/24/24, at 1:33 p.m. Nurse Aide (NA) Employee E23 stated, I have to wait on linens to provide care to the residents unless I go to other floors or laundry to look for some and I may not even find any.</p> <p>During an observation on 7/25/24, at 12:25 p.m. the third-floor high linen room had two washtowels and two towels.</p> <p>During an interview on 7/26/24, at 10:44 a.m. Nursing Home Administrator confirmed that the facility failed to have an ample linen supply at the staff's immediate use on two of three units (second floor and third floor).</p> <p>28 Pa Code: 201.18 (e)(1)(2) Management.</p> <p>28 Pa Code: 201.29 (a)(c)(d) Resident Rights.</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of clinical records, and staff interview it was determined that the facility failed to notify the resident's representative of a change in condition and transfer to the hospital for one of four resident records (Closed Resident Record CR241).</p> <p>Findings include:</p> <p>Review of facility policy Change in Condition: Notification of dated 5/7/24, indicated a Center must immediately notify the patient, consult with the patient's physician, and notify, consistent with their authority, the patient's representative, when there is a significant change in the patient's physical mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions on clinical complications), and when there is a decision to transfer of discharge the patient from the Center.</p> <p>Review of the clinical record indicated Closed Resident Record CR241 was admitted to the facility on [DATE].</p> <p>Review of Closed Resident Record CR241's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/2/24, indicated diagnoses of high blood pressure, history of falling, and muscle weakness.</p> <p>Review of a clinical progress note dated 7/2/24, stated, Patient found by nurse aide not responsive. Oxygen saturation (percentage of oxygen in the blood) at 63% on room air. Started on 6 liters oxygen non-rebreather mask (a device used to assist in the delivery of oxygen), saturations came up to 72% within one minute. 911 called in the meantime. Emergency Medical Services (EMS) in room at this time, face sheet and Medication Administrator Record printed. Supervisor aware. Physician texted.</p> <p>Review of a Situation, Background, Assessment, and Recommendation (SBAR) form dated 7/2/24 indicated, none listed, other than himself in regards to name of family notified of the change in condition.</p> <p>Review of Closed Resident Record CR241's emergency contact list identified a brother as emergency contact number one and a sister as emergency contact number two. Neither emergency contact had a phone number documented.</p> <p>During an interview on 7/25/24, at 1:04 p.m. Admissions Employee E19 stated, There are no documented phone numbers for his emergency contacts because we couldn't get them. I went over Closed Resident Record CR241's admission packet with him and he could not remember their phone numbers. He said they were saved in his phone but he did not have the phone with him. If phone numbers are present on the referral paperwork sent from the hospital, I will use that and enter the emergency contact information in our system.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/25/24, at 1:04 p.m. Admission Employee E19 reviewed Closed Resident Record CR241's hospital face sheet dated 6/27/24. During this interview, it was determined that phone numbers for the emergency contacts were listed on the paperwork provided by the hospital prior to Closed Resident Record CR241's admission to the facility.</p> <p>During an interview on 7/25/24, at 1:04 p.m. Admission Employee E19 stated, That's my fault. I didn't realize the phone numbers were listed there, I missed it.</p> <p>During an interview on 7/25/24, at 1:26 p.m. the Nursing Home Administrator confirmed that the facility failed to notify the resident's representative of a change in condition and transfer to the hospital as required.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa. Code 201.29 (a) Resident rights.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>49469</p> <p>Based on review of facility policy, observation, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of six medication carts (third floor low hall medication cart assignment two).</p> <p>Findings include:</p> <p>Review of facility policy Resident Rights dated 11/28/16, reviewed 5/7/24, indicates a resident has a right to personal privacy and confidentiality of their personal and medical records.</p> <p>During an observation on 7/24/24, at 9:11 a.m. Registered Nurse (RN) Employee E8 went into Resident R113's room to administer medications. RN Employee E8 left the computer screen open with resident information visible to anyone passing by in the hallway.</p> <p>During an interview on 7/24/24, at 9:19 a.m. RN Employee E8 confirmed the facility failed to provide privacy and confidentiality of resident health information on one of six medication carts (third floor low hall medication cart assignment two).</p> <p>28 Pa. Code 201.29(j) Resident rights.</p> <p>28 Pa. Code: 211.5(b) Clinical records.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>48546</p> <p>Based on observations, and staff interview, it was determined that the facility failed to maintain a clean homelike environment for two of three units (second floor shower room and fourth floor nursing unit).</p> <p>Findings include:</p> <p>Review of facility policy Accommodation of Needs dated 5/7/24, indicated the resident/patient has the right to a safe, clean, comfortable, and homelike environment including, but not limited to, receiving treatment and support for daily living safely.</p> <p>Review of the facility policy Cleaning and Disinfecting dated 5/7/24, indicated leaning and disinfecting of frequent touched items and surfaces, resident care items, and the environment, will be conducted routinely and based on risk of infection involved. For durable medical equipment such as feeding pumps, staff shall store used/dirty equipment in soiled utility rooms. Central Supply or designees shall be responsible for terminal cleaning/disinfection in designated locations.</p> <p>During an observation on 7/22/24, at 8:49 a.m. Resident R57's tube feeding pole and floor surrounding the pole were observed dirty with white and yellow stains observed on the floor and pole.</p> <p>During an interview on 7/22/24, at 9:20 a.m. Registered Nurse (RN) Employee E2 confirmed the facility failed to maintain a clean homelike environment for Resident R57.</p> <p>During an observation of the second floor shower room on 7/24/24, at 12:30 p.m. revealed a gray, splotchy substance on the floor where the floor and wall meet.</p> <p>During an interview on 7/24/24, at 12:30 p.m. RN Employee E17 confirmed the presence of a gray, splotchy substance on the floor of the second floor shower room.</p> <p>During an interview on 7/24/24, at 3:15 p.m. the Nursing Home Administrator confirmed that the facility failed to maintain a clean homelike environment for two of three units as required.</p> <p>28 Pa. Code 207.2(2) Administrator's Responsibility.</p> <p>28 Pa. Code: 201.18(b)(3)(e)(1) Management.</p> <p>28 Pa. Code 201.29(j) Resident rights.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on review of facility policy, clinical records, facility documents, and staff interview, it was determined that the facility failed to fully investigate injuries of unknown origin for one of four residents reviewed (Resident R125).</p> <p>Findings include:</p> <p>A review of the facility's Abuse, Neglect, and Exploitation policy dated 5/7/24, indicated immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect the Administrator or designee will initiate a thorough investigation within 24 hours, ensure that documentation of witnessed interviews is included.</p> <p>Review of the clinical record revealed that Resident R125 was admitted to the facility on [DATE], with diagnosis that included high blood pressure, adjustment disorder with anxiety, and muscle weakness.</p> <p>A review of Resident R125's progress note dated 6/5/24, entered by Licensed Practical Nurse (LPN) Employee E32, stated the resident was heard getting up with her canes and walking in the hall, ran to resident and lowered to the floor to prevent injury.</p> <p>A review of the facility's investigation dated 6/5/24, indicated Resident R125 was walking in hallway with two canes, the resident was unstable, approached from behind, and resident began falling, I ran and caught resident prior to hitting the floor. A review of the facility's investigation failed to include any witness statements.</p> <p>A review of Resident R125's physician order dated 6/6/24, indicated to xray the resident's right ankle, right foot, right hip, and right femur due to pain.</p> <p>Review of Resident R125's progress note dated 6/8/24, entered by LPN Employee E33 indicated the resident's xray results were read and indicated the resident has an acute fracture of the intracapsular right femoral neck. The physician was notified and orders were received to transfer resident to hospital.</p> <p>Review of the report submitted to Department of Health on 6/8/24, it was indicated a nurse heard Resident R125 getting up and walking in her room. When the nurse entered the room, she had to lower her to the floor. It was indicated a nurse practitioner assessed the resident the following day, and the resident report right ankle pain. An x-ray was ordered and it was indicated the resident had an acute fracture of the intracapsular right femoral neck (a type of hip fracture of the thigh bone). The resident was transferred to the hospital.</p> <p>Review of Resident R125's hospital discharge summary dated 6/8/24, indicated the resident sustained a right femoral neck fracture.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/24/24, at 2:51 p.m., the Nursing Home Administrator confirmed that the facility failed to investigate injuries of unknown origin for one of four residents reviewed. (Resident R125).</p> <p>28 Pa. Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.14 (c)(e) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (e)(1) Management.</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for four of five residents sampled with facility-initiated transfers (Residents R29, R39, R75, and R82).</p> <p>Findings include:</p> <p>Review of facility policy Discharge and Transfer dated 5/7/24, indicated transfer and discharge includes movement of a patient to a bed outside of the certified Center, whether that bed is in the same physical plant or not.</p> <p>Review of the clinical record indicated Resident R29 was admitted to the facility on [DATE].</p> <p>Review of Resident R29's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/5/24, indicated diagnoses of high blood pressure, muscle weakness, and acute cholecystitis (inflammation of the gallbladder).</p> <p>Review of the clinical record indicated Resident R29 was transferred to hospital on 5/9/24 and returned to the facility on [DATE].</p> <p>Review of Resident R29's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of the clinical record indicated Resident R39 was admitted to the facility on [DATE].</p> <p>Review of Resident R39's MDS dated [DATE], indicated diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and osteoarthritis (degeneration of the joint causing pain and stiffness).</p> <p>Review of the clinical record indicated Resident R39 was transferred to hospital on 10/23/23 and returned to the facility on [DATE].</p> <p>Review of Resident R39's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of the clinical record indicated Resident R75 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R75's MDS dated [DATE], indicated diagnoses of high blood pressure, atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), and thyroid disease (any dysfunction of the butterfly-shaped gland at the base of the neck).</p> <p>Review of the clinical record indicated Resident R75 was transferred to hospital on 5/7/24 and returned to the facility on [DATE].</p> <p>Review of Resident R75's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of admission record indicated Resident R82 was admitted to the facility on [DATE].</p> <p>Review of Resident R82's MDS dated [DATE], indicated the diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain).</p> <p>Review of the clinical record indicated Resident R82 was transferred to hospital on 11/27/23 and returned to the facility on [DATE].</p> <p>Review of Resident R82's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>During an interview on 7/26/24, at 8:31 a.m. the Nursing Home Administrator confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider as required, for four out of five residents sampled with facility-initiated transfers (Residents R29, R39, R75, and R82).</p> <p>28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Shadyside Skilled Nursing and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  5609 Fifth Avenue Pittsburgh, PA 15232	
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for four of five residents (Residents R29, R39, R75, and R82).</p> <p>Findings include:</p> <p>Review of facility policy Discharge and Transfer dated 5/7/24, indicated copies of notices for emergency transfers must also be sent to the Ombudsman, but they may be sent when practicable, such as in a list of patients on a monthly basis or per state requirements.</p> <p>Review of the clinical record indicated Resident R29 was admitted to the facility on [DATE].</p> <p>Review of Resident R29's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/5/24, indicated diagnoses of high blood pressure, muscle weakness, and acute cholecystitis (inflammation of the gallbladder).</p> <p>Review of the clinical record indicated Resident R29 was transferred to hospital on 5/9/24 and returned to the facility on [DATE].</p> <p>Review of Resident R29's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>Review of the clinical record indicated Resident R39 was admitted to the facility on [DATE].</p> <p>Review of Resident R39's MDS dated [DATE], indicated diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and osteoarthritis (degeneration of the joint causing pain and stiffness).</p> <p>Review of the clinical record indicated Resident R39 was transferred to hospital on 10/23/23 and returned to the facility on [DATE].</p> <p>Review of Resident R39's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>Review of the clinical record indicated Resident R75 was admitted to the facility on [DATE].</p> <p>Review of Resident R75's MDS dated [DATE], indicated diagnoses of high blood pressure, atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), and thyroid disease (any dysfunction of the butterfly-shaped gland at the base of the neck).</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record indicated Resident R75 was transferred to hospital on 5/7/24 and returned to the facility on [DATE].</p> <p>Review of Resident R75's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>Review of admission record indicated Resident R82 was admitted to the facility on [DATE].</p> <p>Review of Resident R82's Minimum Data Set, dated dated dated [DATE], indicated the diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain).</p> <p>Review of the clinical record indicated Resident R82 was transferred to hospital on 11/27/23 and returned to the facility on [DATE].</p> <p>Review of Resident R82's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>During an interview on 7/26/24, at 11:11 a.m. the Director of Social Services Employee E20 stated, I didn't know transfers and bed holds are to be on the Ombudsman notification list. I will start including them from now on.</p> <p>During an interview on 7/26/24, at 11:40 a.m. the Nursing Home Administrator confirmed that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division as required.</p> <p>28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</b></p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization ) for four of five resident hospital transfers (Residents R29, R39, R75, and R82).</p> <p>Findings include:</p> <p>Review of facility policy Discharge and Transfer dated 5/7/24, indicated the Bed Hold Notice of Policy &amp; Authorization form will be provided.</p> <p>Review of the clinical record indicated Resident R29 was admitted to the facility on [DATE].</p> <p>Review of Resident R29's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/5/24, indicated diagnoses of high blood pressure, muscle weakness, and acute cholecystitis (inflammation of the gallbladder).</p> <p>Review of the clinical record indicated Resident R29 was transferred to hospital on 5/9/24 and returned to the facility on [DATE].</p> <p>Review of Resident R29's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 5/9/24.</p> <p>Review of the clinical record indicated Resident R39 was admitted to the facility on [DATE].</p> <p>Review of Resident R39's MDS dated [DATE], indicated diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and osteoarthritis (degeneration of the joint causing pain and stiffness).</p> <p>Review of the clinical record indicated Resident R39 was transferred to hospital on 10/23/23 and returned to the facility on [DATE].</p> <p>Review of Resident R39's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 10/23/23.</p> <p>Review of the clinical record indicated Resident R75 was admitted to the facility on [DATE].</p> <p>Review of Resident R75's MDS dated [DATE], indicated diagnoses of high blood pressure, atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), and thyroid disease (any dysfunction of the butterfly-shaped gland at the base of the neck).</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record indicated Resident R75 was transferred to hospital on 5/7/24 and returned to the facility on [DATE].</p> <p>Review of Resident R75's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 5/7/24.</p> <p>Review of admission record indicated Resident R82 was admitted to the facility on [DATE].</p> <p>Review of Resident R82's Minimum Data Set, dated dated dated [DATE], indicated the diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain).</p> <p>Review of the clinical record indicated Resident R82 was transferred to hospital on 11/27/23 and returned to the facility on [DATE].</p> <p>Review of Resident R82's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 11/27/23.</p> <p>During an interview on 7/26/24, at 9:55 a.m. Admission Employee E19, I contact families about the bed hold policy only if they are private pay to see if they want to continue paying for the bed while at the hospital.</p> <p>During an interview on 7/26/24, at 8:31 a.m. the Nursing Home Administrator confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy as required.</p> <p>28 Pa. Code: 201.29(b)(d)(j) Resident rights.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>49469</p> <p>Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure that a baseline care plan that included the minimum healthcare information necessary to properly care for a resident was developed and implemented within 48 hours of admission for 17 of 17 new admissions in the past 30 days.</p> <p>Findings include:</p> <p>A review of facility policy Person-Centered Care Plan last reviewed 5/7/24, indicated the center must develop and implement a baseline person-centered care plan within 48 hours of admission/readmission for each patient/resident that includes the instructions needed to provide effective and person-centered care that meets professional standards of quality care.</p> <p>A review of the facility's new admissions within the past 30 days failed to reveal baseline care plans in the clinical record.</p> <p>During an interview on 7/24/24, at 2:00 p.m. The Nursing Home Administrator stated, The baseline care plans are not being completed, they should be done on admission, however they are not being completed, and confirmed the facility failed to initiate baseline care plans on 17 of 17 new admissions in the past 30 days.</p> <p>28 Pa. Code: 211.12(d)(1)(5) Nursing services</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49469</p> <p>Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans to meet resident care needs for one of four residents (Residents R19).</p> <p>Findings include:</p> <p>Review of facility policy Person-Centered Care Plan last reviewed on 5/7/24, indicate a comprehensive, individualized care plan will be developed within seven days after completion of the comprehensive assessment (admission, annual, or significant change in status and review and revise the care plan after each assessment. The care plan includes measurable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs that are identified in the comprehensive assessments.</p> <p>Review of Resident R19's admission record indicated admission to the facility on [DATE].</p> <p>Review of the MDS (a periodic assessment of care needs) dated 5/4/24, included diagnoses of heart failure (heart can't pump blood the way it should), hypertension (high blood pressure), and peripheral vascular disease (a condition that reduces blood flow to the arms, legs, or other body parts).</p> <p>Review of Resident R19's physician orders dated 4/27/24, indicated Eliquis tablet 5mg (helps to prevent blood clots) two times a day.</p> <p>Review of Resident R19's physician orders dated 7/11/24, indicated anticoagulant Medication Monitoring: Monitor for discolored urine, black tarry stools, sudden severe headache, N&amp;V, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or V/S, SOB, nose bleeds-document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and progress note findings.</p> <p>Review of the Resident R19's care plan revised 7/11/24, failed to include goals and interventions related to anticoagulant use.</p> <p>During an interview on 7/25/24, at 10:11 a.m. the Director of Nursing confirmed the facility failed to develop and implement comprehensive care plans to meet resident care needs for one of four residents.</p> <p>28 Pa. Code 211.11(d) Resident Care Plan.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50075</p> <p>Based on review of facility policy, observations, resident interview and staff interviews it was determined that the facility failed to provide Activity of Daily Living (ADL) assistance for two of seven residents (Residents R82 and R100).</p> <p>Findings include:</p> <p>Review of facility policy Activities of Daily Living (ADLs) dated 5/7/24, indicated the facility must provide the necessary care and services to ensure that a patient ' s ADL abilities are maintained or improved and do not diminish unless circumstances of the patient ' s clinical condition demonstrate that a change was unavoidable. ADL ' s include hygiene, bathing, dressings, grooming, and oral care.</p> <p>Review of admission record indicated female Resident R82 was admitted to the facility on [DATE]</p> <p>Review of Resident R82's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/5/24, indicated the diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain).</p> <p>During an observation on 7/22/24, at 11:22 a.m. female Resident R82 was resting in bed with a large amount of facial hair to the upper lip and chin.</p> <p>During an observation on 7/25/24, at 9:35 a.m. Resident R82 was in the common room sitting with a large amount of facial hair to the upper lip and chin.</p> <p>During an interview on 7/25/24, at 9:37 a.m. Registered Nurse (RN) Employee E14 confirmed that Resident R82 had facial hair to the upper lip and chin.</p> <p>Review of the clinical record indicated that Resident R100 was admitted to the facility on [DATE].</p> <p>Review of Resident R100's MDS dated [DATE], indicated diagnoses of depression, seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures, and hypothyroidism (a condition in which the thyroid gland doesn ' t produce enough thyroid hormone).</p> <p>During an observation on 7/22/24, at 9:25 a.m. female Resident R100 was resting in bed with a large amount of facial hair to the upper lip and chin.</p> <p>During an interview on 7/22/24, at 9:30 a.m. Resident R100 stated, I want it removed and would have it done but they don't do it.</p> <p>During an observation on 7/23/24, at 12:15 p.m. Resident R100 was watching television while laying in bed with a large amount of facial hair to the upper lip and chin.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/23/24, at 12:20 p.m. RN Employee E1 confirmed that Resident R100 had facial hair to the upper lip and chin.</p> <p>During an interview on 7/25/24, at 3:15 the Director of Nursing confirmed the facility failed to provide Activity of Daily Living (ADL) assistance for two of seven residents (Residents R82 and R100).</p> <p>28 Pa. Code 211.10(c)(d) Resident Care Policies</p> <p>28 Pa. Code 211.12 (d)(1)(2)(5) Nursing Services</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure that residents receive proper treatment and assistive devices to maintain hearing abilities for one of eight residents (Resident R57).</p> <p>Findings include:</p> <p>Review of the clinical record indicated that Resident R57 was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - a period assessment of care needs) dated 2/15/24, indicated diagnoses of hypertension (high blood pressure), muscle weakness, and diabetes (a chronic, disease characterized by elevated levels of blood glucose (or blood sugar).</p> <p>Review of Resident R57's Audiology visit summary dated 3/6/24, indicated the patient was referred by the facility for decreased hearing. It was indicated the resident had excessive ear wax in both ears. Recommendations included to refer for ear wax removal in both ears, follow facility protocol for wax removal, debrox (medication used to treat earwax buildup) and ear canal flush as ordered by facility physician. Follow up indicated to establish the resident hearing exam as needed and complete wax management for 1-3 months.</p> <p>Review of Resident R57's clinical record from 3/6/24, through 7/24/24, failed to include an order for the resident's ear wax drops.</p> <p>During an interview on 7/23/24, at 10:07 a.m. Resident R57 indicated she had an audiology appointment a while back and they ordered her ear wax drops and she never received them.</p> <p>During an interview on 7/24/24, at 2:31 p.m. Scheduler Employee E31 confirmed no follow-up appointment had been made for Resident R57.</p> <p>During an interview on 7/24/24, at 2:51 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that residents receive proper treatment to maintain hearing abilities for one of five residents.</p> <p>28 Pa. Code 211.10(a)(c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(3) Nursing services.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</b></p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to properly monitor weight and nutrition status by failing to obtain weights for one of three residents (Resident R12) and failed to provide necessary services for one of three residents reviewed (Resident R106).</p> <p>Findings include:</p> <p>Review of facility policy Weights and Heights dated 5/7/24, indicated patients are weighed upon admission and/or re-admission, then weekly for four weeks and monthly thereafter. Additional weights may be obtained at the discretion of the interdisciplinary care team. Hospital weight will not service as admission or re-admission weight.</p> <p>Review of facility policy NSG270 Meal Service dated 5/7/24, indicated that person-centered meal service includes the delivery of a safe, sanitary, and comfortable environment for meals. It was indicated if a resident requires assistance with eating, do not deliver the tray until assistance can be provided. Staff will provide assistance during meal services to meet patient needs.</p> <p>Review of the clinical record indicated Resident R12 was admitted to the facility on [DATE].</p> <p>Review of Resident R12's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/12/24, indicated diagnoses of adult failure to thrive (seen in older adults with multiple medical conditions resulting in a downward spiral of poor nutrition, weight loss, inactivity, depression, and decrease in functional abilities), cancer (a disease in which abnormal cells divide uncontrollably and destroy body tissue), and abnormal weight loss.</p> <p>Review of Resident R12's care plan dated 6/7/24, indicated the resident is at nutritional risk with a goal of the resident will maintain a stabilized weight without significant changes and improvement in skin integrity through next review date. Interventions include monitor for changes in nutrition status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and report to food and nutrition/physician as indicated.</p> <p>Review of Resident R12's weight record on 7/26/24, failed to reveal any documented weights since Resident R12's admission on 6/5/24.</p> <p>Review of a High Risk Nutrition Note completed by Registered Dietitian Employee E35, dated 7/25/24, stated, No weights recorded in electronic medical record; noted resident will typically refuse to be weighed until pain medication is provided beforehand. Registered Dietitian spoke to mother upon initial admission in 6/2024 who stated that resident may have lost weight in March/April due to sickness, but since then may have gained some weight back.</p> <p>During an interview on 7/26/24, at 11:37 a.m. the Director of Nursing confirmed that the facility failed to properly monitor weight and nutrition status by failing to obtain weights as required.</p> <p>Review of the clinical record indicated Resident R106 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R106's MDS dated [DATE], indicated diagnoses that included Alzheimer's disease (a condition in which nerve cells in the brain drop out, causing a gradual decline in memory and cognitive function), depression, and anxiety.</p> <p>Review of Resident R106's care plan dated 7/11/23, last revised 6/14/24, indicated the resident has the potential for weight loss due to advanced cancer, stroke (occurs when the blood supply to part of the brain is blocked or reduced) with hemiplegia (paralysis of one side of body), Bipolar disorder (a serious mental illness characterized by extreme mood swings), and history of significant weight loss. Interventions included to assist the resident with meals to encourage oral intake.</p> <p>Review of Resident R106's clinical record revealed a current physician order dated 6/14/24, indicated the resident required feeding assistance at all meals to optimize oral intakes.</p> <p>During an observation on 7/22/24, at 9:16 a.m. Resident R106 indicated she was hungry for breakfast and stated, Can I please eat.</p> <p>During an observation on 7/22/24, at 9:24 a.m. Resident R106 was observed sitting in her room unattended with her breakfast tray.</p> <p>During an interview on 7/22/24, at 9:28 a.m. Registered Nurse, Employee E2 confirmed Resident R106 was on the facility's feeding list and the facility failed to assist Resident R106 with her meal as ordered.</p> <p>During an interview on 7/22/24, at 9:37 a.m. Nurse Aide, Employee E22 stated today was her first day back, and she didn't even know Resident R106 was required assistance with meals.</p> <p>During an interview on 7/24/24, at 12:50 p.m. the Nursing Home Administrator confirmed the facility failed to provide necessary services and feed Resident R106 as ordered.</p> <p>28 Pa. Code: 211.10(c) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49469</p> <p>Based on review of clinical records, facility policy, and staff interview, it was determined that the facility failed to obtain physician orders for maintenance flushing of a enteral-tube for one of four residents (Resident R41), failed to obtain orders for enteral-tube displacement for one of four residents (Resident R53), failed to label tube feeding flush kit with dates on 2 of 8 residents (R28 and R41), and failed to label tube feeding formula and water flush on one of eight residents (R53).</p> <p>Review of the facility policy Enteral Management dated 5/7/24, indicate to provide safe and effective management of enteral tubes (a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications).</p> <p>Review of the facility policy Enteral Feeding: Administration by Pump dated 5/7/24, indicate to verify order. Order includes, but is not limited to frequency of water flushes. Evaluate tube and site for damage, leakage, or irritation. If tube is damaged, notify physician for replacement. Label enteral administration set with patients name, room number date, start time and flow rate. Change formula container and administration set and tubing every 24 hours. Rinse and dry syringe, separately store syringe and barrel before storing in labeled or dated plastic bag or container. Syringe can be used for up to 24 hours.</p> <p>Review of Resident R41 clinical records indicated admission to facility on 4/9/24.</p> <p>Review of Resident R41's Minimum Data Set (MDS-periodic assessment of care needs) dated 4/16/24, indicate the diagnosis of anemia (low iron in the blood), atrial fibrillation (irregular heart rhythm), and orthostatic hypotension (low blood pressure that happens when standing after sitting or lying down).</p> <p>Review of physician orders dated 4/10/24, indicate enteral feed enteral feed elevate head of bed 30-45 degrees during feeding &amp;for at least 30-45 minutes after feedings, elevate head of bed 60 min after medication administration via tube.</p> <p>Review of physician orders failed to include orders for frequency of water flushes.</p> <p>During an interview on 7/23/24 at 10:26 a.m. Registered Nurse (RN) E8 stated Resident R41 receives all medications via feeding tube.</p> <p>During an interview 7/23/24, at 10:27 a.m. RN Employee E1 confirmed the facility failed to obtain physician orders for maintenance flushing of a enteral feeding tube for one of four residents.</p> <p>Review of Resident R53's clinical record indicated admitted [DATE].</p> <p>Review of Resident R53's MDS dated [DATE], indicate the diagnosis of anemia (low iron in the blood) hypertension (high blood pressure), and malnutrition (lack of proper nutrition that results from eating too little, too much, or the wrong nutrients).</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R53's physician orders dated 2/2/24 indicate enteral feed order in the afternoon Start at 8:00 p.m.; flush w/ 30mL water then provide Jevity 1.5 at 60mL/hour x12hrs or until total volume of 720mL is reached. Provide 25mL water flush every one hour while infusing to prevent clogging Keep HOB &gt;30 degree while infusing.</p> <p>Review of physician orders failed to include orders for enteral feeding displacement.</p> <p>During an interview on 7/24/24, at 10:36 a.m. RN Employee E9 confirmed the facility failed to obtain orders for enteral feeding displacement for one of four residents.</p> <p>Review of the clinical record indicated Resident R28 was admitted to facility on 9/21/23.</p> <p>Review of Residents R28 MDS dated [DATE] indicate the diagnosis of stroke (death of a region of brain cells due to poor blood flow), coronary artery disease (limits blood flow to arteries), and hypertension (high blood pressure).</p> <p>Review of Resident R28's physician orders dated 9/22/23 indicate enteral feed, change syringe every 24 hours.</p> <p>During an observation 7/22/24 at 9:18 a.m. a tube feeding flush kit on Resident R28's bedside stand, the kit failed to be labeled with date and time.</p> <p>During an interview 7/22/24 at 9:19 a.m. RN Employee E8 confirmed the facility failed to label Resident R 28's tube feeding flush kit with date and time.</p> <p>Review of Resident R41 clinical records indicated admission to facility on 4/9/24.</p> <p>Review of Resident R41's MDS dated [DATE], indicate the diagnosis of anemia (low iron in the blood), atrial fibrillation (irregular heart rhythm), and orthostatic hypotension (low blood pressure that happens when standing after sitting or lying down).</p> <p>Review of Resident R41's physician orders dated 4/30/24, indicate enteral feed, change syringe daily.</p> <p>During an observation on 7/22/24, at 9:02 a.m. Resident R41's feeding flush kit was on bedside stand, the kit failed to be labeled with date and time</p> <p>During an interview 7/22/24, at 9:08 a.m. RN Employee E8 confirmed the facility failed to label Resident R 41's tube feeding flush kit with date and time.</p> <p>Review of Resident R53's clinical record indicated admitted [DATE].</p> <p>Review of Resident R53's MDS dated [DATE], indicate the diagnosis of anemia (low iron in the blood) hypertension (high blood pressure), and malnutrition (lack of proper nutrition that results from eating too little, too much, or the wrong nutrients).</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R53's physician orders dated 2/2/24 indicate enteral feed order in the afternoon Start at 8:00 p.m.; flush w/ 30mL water then provide Jevity 1.5 at 60mL/hour x12hrs or until total volume of 720mL is reached. Provide 25mL water flush every one hour while infusing to prevent clogging Keep HOB &gt;30 degree while infusing.</p> <p>During an observation on 7/22/24, at 09:03 AM Resident R53's Jevity and water bag were hanging on tube feeding pole and failed have a label with name, room number date, start time and flow rate.</p> <p>During an interview 7/22/24, at 9:08 a.m. RN Employee E8 confirmed the facility failed to label Resident R 53's tube feeding formula and water flush name, room number date, start time and flow rate.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.11(d) Resident care policies.</p> <p>28 Pa. Code 201.29(d) Resident Rights</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on review of facility policy, observations, interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for two of four residents (Residents R94 and R106).</p> <p>Findings include:</p> <p>Review of facility policy Procedure: Oxygen: Nasal Cannula dated 5/7/24, indicated if a humidifier is used it must be labeled with the date. It was indicated the flow rate of oxygen must be set to the prescribed order.</p> <p>Review of the clinical record indicated Resident R94 was admitted to the facility on [DATE], with diagnoses of muscle weakness, high blood pressure, and Chronic Pulmonary Disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>Review of Resident R94's Minimum Data Set (MDS - a periodic assessment of care needs dated 7/16/24, indicated the diagnoses were current.</p> <p>Review of Resident R94's care plan dated 1/14/22, indicated to administer oxygen as per physician order.</p> <p>Review of Resident R94's physician order dated 7/10/24, indicated to change oxygen tubing every Wednesday night shift and to label each component with date and initials.</p> <p>Review of Resident R94's clinical record on 7/22/24, at 8:57 a.m. revealed a current physician order dated 4/1/24, to administer 3 liters oxygen per minute (refers to the flow rate of oxygen provided to a patient. It is measured in liters per minute (LPM)) via nasal cannula (a device that delivers extra oxygen through a tube and into your nose) as needed.</p> <p>During an observation on 7/22/24, at 8:58 a.m. Resident R94 was observed receiving 5.5 liters of oxygen via nasal cannula. The resident's humidification bottle (a medical device that increase the humidity in your oxygen while using supplemental oxygen) was not dated and was empty with a white dry substance located in the humidification container.</p> <p>During an interview on 7/22/24, at 9:10 a.m. Nurse Aide (NA) Employee E21 confirmed Resident R94 was not receiving oxygen as ordered, and the resident's humidification bottle was undated and empty.</p> <p>During an interview on 7/23/24, at 2:34 p.m. the Nursing Home Administrator confirmed the facility failed to provide appropriate respiratory care for Resident R94.</p> <p>Review of the clinical record indicated Resident R106 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease, (a condition in which nerve cells in the brain drop out, causing a gradual decline in memory and cognitive function), depression, and anxiety.</p> <p>Review of Resident R106's MDS dated [DATE], indicated diagnoses were current.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R106's care plan dated 4/28/24, indicated to administer oxygen as per physician order at 2 liters via nasal cannula.</p> <p>Review of Resident R106's clinical record on 7/22/24, at 8:42 a.m. revealed a current physician order dated 4/12/24, to administer 2 liters of oxygen per minute via nasal cannula.</p> <p>During an observation on 7/22/24, at 8:45 a.m. Resident R106 was observed receiving 6 liters of oxygen via nasal cannula. No date was observed on the tubing, and the resident was not receiving humidification.</p> <p>During an interview on 7/22/24, at 10:30 a.m. NA Employee E21 confirmed Resident R106 was not receiving oxygen as ordered, and the facility failed to date the resident's humidification and nasal cannula tubing.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</b></p> <p>Based on review of resident clinical records, facility policy and staff interview it was determined the facility failed to provide consistent and complete communication with the dialysis (a machine that filters wastes, salts, and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) center for three of three residents (Residents R1, R27, and R41).</p> <p>Findings include:</p> <p>Review of facility policy Dialysis: Hemodialysis (HD) - Communication and Documentation dated 5/7/24, indicated Center staff will communicate with the certified dialysis facility regarding the ongoing assessment of the patient's condition by monitoring for complications before and after hemodialysis treatments received at a certified dialysis facility. To ensure ongoing communication and collaboration with the certified dialysis facility regarding hemodialysis (HD) patient care and services. Practice Standards:</p> <ol style="list-style-type: none"> <li>1. Prior to a patient leaving the Center for HD, a licensed nurse will complete the top portion of the Hemodialysis Communication Record or the state required form and send with the patient to his/her HD facility visit.</li> <li>2. Following completion of the HD, the dialysis facility nurse should complete and return the form and return it or other communication to the Center with the patient.</li> <li>3. Upon return of the patient to the Center, a licensed nurse will:             <ol style="list-style-type: none"> <li>3.1 Review the certified dialysis facility communication.</li> <li>3.2 Evaluate/observe the patient; and</li> <li>3.3 Complete the post-hemodialysis treatment section on the Hemodialysis Communication Record or state required form.</li> </ol> </li> <li>4. Notify the certified dialysis facility if the form is not returned with the patient and ask that it be faxed to the Center.             <ol style="list-style-type: none"> <li>4.1 Document notification of certified dialysis facility regarding return of form or other communication.</li> </ol> </li> <li>5. Maintain the Hemodialysis Communication Record or state required form in the patient ' s</li> </ol> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>medical record.</p> <p>Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].</p> <p>Review of Resident R1's MDS (MDS - a periodic assessment of care needs) dated 6/10/24, indicated diagnoses of high blood pressure, end stage renal disease (ESRD - an inability of the kidneys to filter the blood), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time).</p> <p>Review of a physician order dated 7/5/23, indicated the resident received dialysis treatments three times a week every Monday, Wednesday, and Friday.</p> <p>Review of Resident R1's Dialysis Communication forms failed to reveal completed forms for four of 16 days (7/1/24, 7/8/24, 7/12/24, and 7/19/24).</p> <p>During an interview on 7/23/24, at 12:26 p.m. Registered Nurse (RN) Employee E1 confirmed that the Dialysis Communication forms were not completed by the facility.</p> <p>Review of the clinical record indicated Resident R27 was admitted to the facility on [DATE].</p> <p>Review of Resident R27's MDS dated [DATE], indicated diagnoses of high blood pressure, end stage renal disease, and muscle weakness.</p> <p>Review of a physician order dated 7/8/24, indicated the resident received dialysis treatments three times a week every Tuesday, Thursday, and Saturday.</p> <p>Review of Resident R27's Dialysis Communication forms failed to reveal completed forms for 10 of 16 days (6/18/24, 6/20/24, 6/22/24, 6/27/24, 6/29/24, 7/2/24, 7/4/24, 7/6/24, 7/13/24, and 7/20/24).</p> <p>During an interview on 7/24/24, at 12:23 p.m. RN Employee E17 stated, If there were completed forms, they would be in the resident's chart. If they aren't there, they probably weren't completed.</p> <p>During an interview on 7/24/24, at 12:53 p.m. the Nursing Home Administrator confirmed that the facility failed to provide consistent and complete communication with the dialysis center for Resident R27 as required.</p> <p>Review of Resident R41 clinical records indicated admission to facility on 4/9/24.</p> <p>Review of Resident R41's MDS dated [DATE], indicate the diagnosis of anemia (low iron in the blood), atrial fibrillation (irregular heart rhythm), and orthostatic hypotension (low blood pressure that happens when standing after sitting or lying down).</p> <p>A review of a physician's order dated 4/10/24, indicated dialysis three days a week every Tuesday, Thursday, and Saturday.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the Resident R41's dialysis communication sheets revealed no sheets were available for 21 of 22 days 4/11/24, through 5/28/24. An incomplete dialysis communication sheet was produced for 5/30/24. No dialysis communication sheets were available for 13 of 22 days (6/1/24, 6/4/24, 6/6/24, 6/8/24, 6/11/24, 6/13/24, 6/15/24, 6/18/24, 6/25/24, 6/27/24, 6/29/24, 7/11/24, 7/18/24). The dialysis communication sheets were incomplete with no facility post dialysis treatment completed for 8 of 22 days (6/20/24 and 6/22/24, 7/2/24, 7/4/24, 7/6/24, 7/13/24, 7/16/24, 7/20/24).</p> <p>During an interview completed on 7/23/24, RN Employee E1 confirmed the facility failed to complete a dialysis communication form or complete accurate dialysis communication forms as above noted for Resident R41.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p> <p>28 Pa. Code: 201.18(b)(e)(1)(2) Management</p> <p>28 Pa. Code: 201.29(a)(b)(c)(d)(j)(m) Resident rights.</p> <p>28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee.</p>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of facility policy, personnel records and staff interview it was determined that the facility failed to complete annual performance evaluations for two out of five nurse aide personnel records (Nurse Aide (NA) Employee E25 and NA Employee E26).</p> <p>Findings include:</p> <p>Review of facility policy Performance Appraisal dated 5/7/24, indicated managers will meet with their regular full-time, regular part-time, and regular casual employees at least annually to conduct a performance appraisal or have a performance based conversation.</p> <p>Review of NA Employee E25's personnel record indicated she was hired to the facility on [DATE].</p> <p>Review of NA Employee E26's personnel record indicated she was hired to the facility on [DATE].</p> <p>Review of personnel records did not include an annual performance evaluation based on the date of hire for NA Employee E25 and NA Employee E26.</p> <p>During an interview on 7/26/24, at 9:55 a.m. Scheduler Employee E18 confirmed that the facility failed to complete annual performance evaluations based on date of hire for NA Employee E25 and NA Employee E26 as required.</p> <p>28 Pa Code: 201.20 (a)(b)(c)(d) Staff development.</p>		

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NAME OF PROVIDER OR SUPPLIER  Shadyside Skilled Nursing and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  5609 Fifth Avenue Pittsburgh, PA 15232	
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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on clinical records and facility policy review, and staff interview, it was determined that the facility failed to ensure that a resident who displayed mental or psychosocial adjustment difficulties received appropriate treatment and services to correct the problem for one of three residents (Resident R84).</p> <p>Findings include:</p> <p>Review of the facility OPS416 Person-Centered Care Plan dated 5/7/24, indicated a comprehensive person-centered care plan must be developed for each patient and must describe the services that are to be furnished. The care plan must be customized to each individual resident's preferences and needs.</p> <p>Review of the facility policy NSG206 Behaviors: Management of Symptoms dated 5/7/24, indicated residents exhibiting behavioral symptoms will be individually evaluated to determine the behavior. Behaviors and interventions will be addressed in the care plan. The facility will ensure necessary behavioral health services are person-centered and reflect the patient's goal of care, while maximizing the patient's dignity, autonomy, privacy, socialization, independence, choice, and safety.</p> <p>Review of the clinical record indicated Resident R84 was admitted to the facility on [DATE].</p> <p>Review of Resident R84's Minimum Data Set (MDS- assessment of a resident's abilities and care needs) dated 7/2/24, indicated diagnoses of depressive, auditory hallucinations (when a person hears sounds or voices that are not actually present), and psychotic disorder (a group of serious illnesses that affect the mind, which make it hard for someone to think clearly, make good judgments, respond emotionally, communicate effectively, understand reality, and behave appropriately).</p> <p>Review of the nursing progress notes dated 7/15/24, indicated the resident sometimes feels lonely or isolated from those around her.</p> <p>Review of Resident R84's care plan dated 4/22/24, indicated the resident has paranoia and suspiciousness as evidenced by saying things that are not true and has verbal aggression related to an unknown etiology. Review of Resident R84's care plan revised failed to include a care plan for the resident's depression and psychotic disorder.</p> <p>During an observation on 7/22/24, at 8:34 a.m. Resident R84 was observed lying in bed screaming out indicating she had to go to the bathroom.</p> <p>During an observation on 7/22/24, at 9:35 a.m. Resident R84's call light was on and was observed screaming out, I am not feeling well, and, Please help me, I am not going home today, I will call the police.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 7/22/24, at 9:36 a.m. Nurse Aide Employee E30 was observed going into Resident R84's room and turning off her call light and removing the resident's breakfast tray.</p> <p>During an observation on 7/22/24, at 9:39 a.m. Resident R84 was observed yelling out.</p> <p>During an interview on 7/25/24, at 9:38 a.m. Registered Nurse Assessment Coordinator Employee E29 confirmed the facility failed to ensure Resident R84 received appropriate treatment and services for mental or psychosocial adjustment difficulties.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on a review of clinical records and staff interview, it was determined that the facility failed to ensure a resident with dementia receives the appropriate treatment and services to attain or maintain his highest practicable physical, mental, and psychosocial well-being for one of four residents reviewed (Resident R106).</p> <p>Findings include:</p> <p>Review of the facility OPS416 Person-Centered Care Plan dated 5/7/24, indicated a comprehensive person-centered care plan must be developed for each patient and must describe the services that are to be furnished. The care plan must be customized to each individual resident's preferences and needs.</p> <p>Review of Resident R106's clinical record indicated the resident was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease, (a form of dementia which causes a gradual decline in memory, thinking and reasoning skills), depression, and anxiety. A Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated 6/19/24, indicated the diagnoses were current.</p> <p>Review of Resident R106's care plan dated 7/17/24, indicated the resident exhibits or has the potential to demonstrate verbal behaviors related to cognitive loss and dementia resulting in false accusations. Interventions include to provide care in pairs. No further care interventions were included. The facility failed to implement an individualized care plan for dementia.</p> <p>During an interview on 7/25/24, at 10:26 a.m. the Director of Nursing confirmed the facility failed to ensure a resident with dementia receives the appropriate treatment and services to attain or maintain his highest practicable physical, mental, and psychosocial well-being for one of four residents reviewed (Resident R106).</p> <p>28 Pa Code 211.12 (d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49469</p> <p>Based on review of facility policies, observations and staff interview it was determined that the facility failed to store all drugs and biologicals in a safe, secure, and orderly manner for two of three units (third floor medication room and fourth floor medication room).</p> <p>Findings include:</p> <p>Review of the facility policy Medication Administration dated [DATE], indicated the nurse shall place a date opened sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened.</p> <p>Review of the facility policy Medication Storage dated [DATE], indicate medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. Any other foods such as employee lunches and activity department refreshments should not be stored in this refrigerator. The refrigerator should be kept clean and frost-free.</p> <p>Observation on [DATE], at 10:17 a.m. the third-floor medication room refrigerator contained one vial of tuberculin solution noted to be opened and without a date. A brown slime was noted on the refrigerator's bottom drawer, a pink sticky/slime was noted in the refrigerator door seal. The freezer contained a pink sticky substance on the bottom shelf and a blue frozen water bottle.</p> <p>During an interview on [DATE], at 10:21 a.m. Registered Nurse (RN) Employee E1 confirmed the facility failed to store drugs and biologicals in a safe, secure, and orderly manner for one of three units (third floor medication room).</p> <p>Observation on [DATE], at 9:22 a.m. of the fourth floor medication room revealed the following supplies were expired:</p> <p>- (5) Glucose Control Solutions EVENCARE G expired [DATE]</p> <p>- (1) 0.9% NSS 100ml expired ,d+[DATE]</p> <p>- (1) Universal Viral Transport for viruses, Chlamdiae, Mycoplasmas, and Urea plasmas-swab kit expired [DATE]</p> <p>During an interview on [DATE], at 9:24 a.m. LPN Employee E33 confirmed the facility failed to store drugs and biologicals in a safe manner for one of three units (fourth floor medication room).</p> <p>28 Pa. Code: 211.10(c) Resident care policies.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code: 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50075</p> <p>Based on review of clinical records, and staff interview it was determined that the facility failed to ensure that a resident's laboratory test results were received for one of seven residents (Resident R75).</p> <p>Findings include:</p> <p>Review of facility policy Cultures/Culture Reports dated 5/7/24, indicated the facility that resident culture results will be communicated promptly to the attending physician or advanced practice provider to ensure that all infections are promptly and properly identified through accurate evaluation of culture results for patient care. Practice standards include: Report all culture results promptly to physician and document the results of culture, notification and response of attending physician.</p> <p>Review of the clinical record indicated Resident R75 was admitted to the facility on [DATE].</p> <p>Review of Resident R75's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 1/10/24, indicated diagnoses of high blood pressure, atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), and thyroid disease (any dysfunction of the butterfly-shaped gland at the base of the neck).</p> <p>Review of Resident R75's physician orders revealed an order written on 6/10/24, that indicated Urinalysis with Culture and Sensitivity (a urine test to check for bacteria) due to fatigue (tiredness).</p> <p>Review of Resident R75's clinical record reveal resident had Urinalysis specimen obtained per physician's order on 6/12/24, and the lab was notified for pick up.</p> <p>Review of Resident R75's clinical record reveal that the facility failed to obtain Resident R75's urinalysis results.</p> <p>During an interview on 7/24/24, at 12:45 p.m. Registered Nurse (RN) Employee E1 confirmed that the facility failed to monitor pending urinalysis results, and failed to follow up with lab after a sample was sent to be tested for results. RN Employee E1 stated Someone should have followed up with the lab to get his results so the physician could look at it.</p> <p>During an interview on 7/24/24, at 12:58 p.m. RN Employee E1 confirmed that the facility failed to ensure that a resident's laboratory test results were received for one of seven residents (Resident R75).</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services.</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50075</p> <p>Based on facility documents, clinical records, observations, and staff interviews, it was determined that the facility failed to provide food in a form to meet individuals needs who are ordered easy to chew diet textures for one of five residents (Resident R45).</p> <p>Findings include:</p> <p>Review of facility policy Meal Service dated 5/7/24, indicated that person-centered meal service includes the delivery of a safe, sanitary, and comfortable environment for meals while accommodates patient preference and personal choice. Meal service may occur in dining rooms, patient room, and other suitable locations that promote a homelike environment. The purpose is to provide safe, sanitary, and dignified meal services which account for patient preference. When assisting residents, assure the correct meal is served to the patient.</p> <p>Review of the clinical record indicated Resident R45 was admitted to the facility on [DATE].</p> <p>Review of Resident R45's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/12/24, indicated diagnoses of high blood pressure, cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), and coronary artery disease (damage or disease in the heart's major blood vessels). MDS Section K0520 Nutritional Approaches indicated Resident R45 is coded as mechanically altered diet.</p> <p>Review of Resident R45's physician orders dated 8/15/23, indicated resident to receive regular diet, dysphagia (difficult swallowing) advanced.</p> <p>During an observation on 7/23/24, at 1:14 p.m. Resident R45 was in his room eating lunch. Observed on his tray was a link Italian sausage on a bun, mixed vegetables, red skin potatoes, peanut butter and jelly sandwich with crust, cinnamon applesauce, and drinks.</p> <p>During an observation on 7/23/24, at 1:15 p.m. Resident R45 meal ticket read Regular-Dysphagia Advanced - 2 % milk, Ensure, Ground Italian Sausage, marinara sauce, sauteed peppers and onions, carrots, mashed potatoes with gravy, cinnamon apples, peanut butter and jelly sandwich.</p> <p>During an interview on 7/23/24, at 1:17 p.m. Registered Nurse (RN) Employee E2 stated, His meat should be ground up, like chopped. I'm not sure about the potatoes. I'll get him a new tray.</p> <p>During an interview on 7/23/24, at 1:25 p.m. Speech Language Pathologist Employee E3 stated, A Dysphagia Advanced diet would be the same as mechanical soft (a type of texture-modified diet for people who have difficulty chewing and swallowing). He should not have gotten that tray.</p> <p>During an interview on 7/23/24, at 1:33 p.m. Cook/Chef Employee E4 stated, Resident R45 should have gotten mechanical soft sausage, mashed potatoes, and little dices of carrots. We don't give them red skin potatoes. There are two people on the tray line to check meal tickets. T he cook and the checker should have checked the plate for accuracy. They must not have done that.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/23/24, at 3:15 p.m. Director of Nursing confirmed that the facility failed to provide food in a form to meet individuals needs who are ordered easy to chew diet textures in one of five residents (R45).</p> <p>28 Pa. Code: 211.6(d) Dietary services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49469</p> <p>Based on review of facility policy, observations, and staff interview, it was determined the facility failed to properly label and date food products, failed to properly monitor food temperatures, failed to maintain kitchen equipment and dry storage area in a clean sanitary condition, and failed to properly monitor food expiration dates in a manner to prevent foodborne illness in the Main Kitchen.</p> <p>Findings include:</p> <p>Review of the facility policy Food Handling last reviewed 5/7/24, indicated foods are stored, prepared, and served in a safe and sanitary manner to prevent bacterial contamination and possible spread of infection. Food thermometers are available to all employees who are responsible for checking the internal temperature and holding temperature of foods. Tray line holding food temperatures are taken and recorder on the production worksheets at the beginning of each meal service. Foods that are marked with the manufactures use by date that are properly stored can be used until that date as long as the product has not been combined with any other food or prepared in a way including portioning. Foods in dry storage are in closed, labeled, and dated containers.</p> <p>During an observation of the main kitchen on 7/22/24, at 6:20 a.m. the following was observed:</p> <ul style="list-style-type: none"> <li>-Mixing bowls were stored not inverted on 3rd shelf next to cooler.</li> <li>-Pot rack with pots and pans not inverted.</li> <li>-Black cart with a white substance over the top shelf.</li> <li>-Floors with scattered debris (food and paper items)</li> <li>-Drawer with prep tools with visible brown/rusty substance on drawer edge.</li> </ul> <p>During an interview on 7/22/24, at 6:56 a.m. Dietary Employee E12 confirmed the above observations and that the facility failed to properly store kitchen ware/utensils and failed to properly clean and sanitize kitchen area.</p> <p>During an observation and interview on 7/22/24, at 6:30 a.m. the walk-in cooler in the Main Kitchen</p> <ul style="list-style-type: none"> <li>- the top shelf had a brownish sticky substance</li> <li>- a container on the bottom shelf labeled ham with a red stained lid and use by date of 7/7/24.</li> <li>- A sandwich in a paper bag no label or date.</li> <li>- A bowl of tomato soup with use by date of 7/20/24.</li> </ul> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- Three bowls of chicken noodle soup with no use by date.</p> <p>- A jar of grape jelly with no opened date or use by date</p> <p>Dietary Employee E12 confirmed the above observations.</p> <p>During an observation and interview on 7/22/24, at 6:40 a.m. the small cooler next to dry goods storage room contained:</p> <ul style="list-style-type: none"> <li>- Three trays of fruit cups with no prepared dates or use by dates,</li> <li>- An open container labeled cottage cheese with no open or use by date.</li> <li>- Two boxes labeled creamer with the expiration date of 7/20/22.</li> </ul> <p>Dietary Employee E12 confirmed the above observations.</p> <p>During an observation and interview on 7/22/24, at 7:34 a.m. the dry goods storage area contained:</p> <ul style="list-style-type: none"> <li>- Jiff peanut butter no date opened or expiration date.</li> <li>- Four bins containing dry cereal, the lids had a dust like substance on them</li> <li>- bin unlabeled bin containing no opened or use by dates</li> <li>- bin labeled rice krispy with open date of 4/8/24 and use by date of 5/2/24</li> <li>- bin labeled cheerios no date opened or use by dates.</li> <li>- bin labeled frosted flakes no open date or use by date</li> </ul> <p>Food service director Employee E10 confirmed the above observations.</p> <p>During an observation and interview on 7/22/24, at 7:40 am, Dietary Employee E12 was unable to produce temperatures for breakfast items on the steam table. Dietary Employee E12 stated, I took the temperatures, I just don't know where to write them down, I just remember them.</p> <p>During an interview on 7/23/24, at 1:05 p.m. Food Service Director Employee E10 confirmed that the facility failed to properly monitor food temperatures and confirmed food temperatures are not done consistently. Food service director Employee E10 stated, I do them when I am here.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 211.6(c) Dietary services.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end of life care for two of two residents (Residents R31 and R97).</p> <p>Findings include:</p> <p>Review of facility policy Hospice dated 5/7/24, indicated each patient's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the Center attain or maintain the patient's highest practicable physical, mental, and psychosocial wellbeing. The Administrator will obtain a written agreement with each hospice that includes a communication process, including the method for documenting the communication between the Center and the hospice provider to ensure that the patient's needs are met 24 hours per day.</p> <p>Review of the clinical record indicated Resident R31 was admitted to the facility on [DATE].</p> <p>Review of Resident R31's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/21/24, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), high blood pressure, and cerebrovascular disease (a conditions that affect blood flow to your brain).</p> <p>Review of a physician order dated 4/26/24, indicated to admit to hospice for a diagnoses of cerebral atherosclerosis (the result of thickening and hardening of the walls of the arteries in the brain).</p> <p>During an interview on 7/23/24, at 2:50 p.m. Registered Nurse (RN) Employee E17 confirmed that they were unable to locate a hospice communication binder for Resident R31.</p> <p>Review of the clinical record indicated Resident R97 was admitted to the facility on [DATE].</p> <p>Review of Resident R97's MDS dated [DATE], indicated diagnoses of dementia, weakness, and need for assistance with personal care.</p> <p>Review of a physician order dated 7/15/24, indicated to admit to hospice for a diagnoses of dementia.</p> <p>During an interview on 7/24/24, at 12:26 p.m. RN Employee E17 confirmed that they were unable to locate a hospice communication binder for Resident R97.</p> <p>During an interview on 7/25/24, at 10:11 a.m. the Nursing Home Administrator confirmed that the facility did not have a hospice communication binder for Resident R97.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Shadyside Skilled Nursing and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  5609 Fifth Avenue Pittsburgh, PA 15232	
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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R97's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to included contact information for the hospice agency and how to access the hospice's 24 hour on-call system.</p> <p>During an interview on 7/26/24, at 11:37 a.m. the Director of Nursing confirmed that the facility failed to ensure the coordination of hospice services with the facility services to meet the needs of Resident R97.</p> <p>28 Pa. Code 211.2(a) Physician services.</p> <p>28 Pa. Code 211.11(d) Resident care plan.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>48546</p> <p>Based on review of facility policy, Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all of the required committee members for three of three quarters (October 2023 through December 2023, January 2024 through March 2024, and April 2024 through June 2024).</p> <p>Findings include:</p> <p>Review of facility policy Center Quality Assurance Performance Improvement Process dated 5/7/24, indicated the QAA committee functions under the authority of the Administrator and the Governing Body and is composed of the Administrator, Director of Nursing, Medical Director, Infection Preventionist, consultant pharmacist, patient and/or family representatives, and three additional staff representatives. The QAA committee meets at least quarterly.</p> <p>During an interview on 7/26/24, at 8:15 a.m. the Nursing Home Administrator (NHA) stated that the facility was unable to locate any Quality Assurance and Performance Improvement sign-in sheets and attendance records for October 2023 through December 2023, January 2024 through March 2024, and April 2024 through June 2024.</p> <p>During an interview on 7/26/24, at 8:15 a.m. the NHA confirmed that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all of the required committee members as required.</p> <p>28 Pa Code: 201.18(e )(1)(2)(3)(4) Management.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50075</p> <p>Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to prevent cross contamination during a medication pass for two of six residents (Residents R46 and R98), and failed to follow enhanced barrier precautions (EBP) for eight of eight residents with tube feedings (R6, R28, R41, R53, R72, R73, R75, and R109), six of six residents with indwelling urinary catheters (R12, R38, R39, R75, R238, and R240), and two of two residents with indwelling dialysis catheters (R27 and R42).</p> <p>Findings include:</p> <p>Review of facility policy Medication Administration dated 5/7/24, indicated to administer oral medications in an organized, accurate, and safe manner. Pour the correct number of tablets or capsules into the medication cup, taking care to avoid touching any of the medication unless wearing gloves.</p> <p>Review of the facility policy Enhanced Barrier Precautions (EBP) last reviewed 5/7/24, indicated in addition to Standard Precautions, EBP will be used (when Contact Precautions do not otherwise apply) for novel or targeted multi-drug resistant organisms (MDROs). EBP is based on the Centers for Disease Control &amp; Prevention (CDC) guidance, Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs).</p> <p>Review of the Center for Disease Control (CDC) and Prevention Enhanced Barrier Precautions in Skilled Nursing Facilities dated 11/15/22 indicates EBP should be used for residents with any of the following:</p> <ul style="list-style-type: none"> <li>- Infection or colonization with an MDRO when Contact Precautions do not apply</li> <li>- Wounds</li> <li>- Indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy, ventilator)</li> </ul> <p>Review of the clinical record indicated Resident R46 was admitted to the facility on [DATE].</p> <p>Review of Resident R46's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/8/24, indicated diagnoses of depression, cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), and coronary artery disease (damage or disease in the heart's major blood vessels).</p> <p>Review of Resident R46's physician orders dated 7/3/23, indicated resident to receive:</p> <ul style="list-style-type: none"> <li>- Baclofen 10mg three times a day (for muscle spasms) dated 7/23/24</li> </ul> <p>During an observation on 7/24/24, at 12:35 p.m. Licensed Practical Nurse (LPN) Employee E5 removed medication from package into hand and put it into the medication cup without wearing gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/24/24, at 12:37 p.m. LPN Employee E5 confirmed that he did not use gloves to handle Resident R46's medication.</p> <p>Review of the clinical record indicated Resident R98 was admitted to the facility on [DATE].</p> <p>Review of Resident R98's MDS dated [DATE], indicated diagnoses of depression, anemia (too little iron in the body causing fatigue), and orthostatic hypotension (a form of low blood pressure that happens when standing up from sitting or lying down).</p> <p>Review of Resident R98's physician orders indicated resident to receive:</p> <ul style="list-style-type: none"> <li>- Cyclobenzaprine HCl 7.5 mg three times a day (for muscle spasms) dated 10/18/23</li> <li>- Baclofen 20mg four times a day (for muscle spasms) dated 5/2/24</li> <li>- Neurontin 300mg three times a day (for pain) dated 11/20/23</li> </ul> <p>During an observation on 7/24/24, at 12:39 p.m. LPN Employee E5 removed medication from package into hand and put it into the medication cup without wearing gloves.</p> <p>During an interview on 7/24/24, at 12:40 p.m. LPN Employee E5 confirmed that he did not use gloves to handle Resident R98's medication.</p> <p>During an interview on 7/24/24, at 3:00 p.m. Director of Nursing confirmed that the facility failed to prevent cross contamination during a medication pass for two of six residents (Residents R46 and R98).</p> <p>During an interview 7/24/24, at 10:26 a.m. Infection Preventionist Employee E9 confirmed that Enhanced Barrier Precautions (EBP) were not implemented for residents that have tube feedings, indwelling urinary catheters, or indwelling dialysis catheters and stated, I was not aware of all items included in EBP, I missed the update, and confirmed the facility failed to implement EBP on residents that have tube feedings, foley catheters, and dialysis catheters.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.12 (d)(1)2)(3) Nursing Services</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to make certain that an influenza and pneumococcal immunization was offered to four of five residents (Resident R53, R94, R106, and R112).</p> <p>Findings include:</p> <p>Review of the facility policy IC600 Influenza Immunization dated 5/7/24, indicated influenza immunization history will be obtained and documented upon admission for residents.</p> <p>Review of the facility policy OC601 Pneumococcal Vaccination dated 5/7/24, indicated the facility will provide the opportunity to receive the appropriate pneumococcal vaccine to all residents. Upon admission, obtain the pneumococcal vaccination history of all residents and document in the electronic record.</p> <p>Review of the Admission Record indicated that Resident R53 was admitted to the facility on [DATE].</p> <p>Review of Minimum Data Set (MDS-periodic assessment of care needs) dated 2/4/24, included diagnoses of a seizure disorder and high blood pressure. Section O0250 Influenza Vaccine indicated the resident did not receive the influenza vaccine in the facility, and the reason was not indicated. Section O0300 Pneumococcal Vaccine indicated Resident R53 was not offered the pneumonia vaccination.</p> <p>Review of the clinical record failed to include documentation of that the influenza and pneumonia vaccination and education was provided to Resident R53.</p> <p>Review of the Admission Record indicated that Resident R94 was admitted to the facility on [DATE].</p> <p>Review of MDS dated [DATE], included diagnoses of depression and high blood pressure. Section O0250 Influenza Vaccine indicated the resident was not offered the influenza vaccine in the facility.</p> <p>Review of the clinical record failed to include documentation of that the influenza vaccination and education was provided to Resident R94.</p> <p>Review of the Admission Record indicated that Resident R106 was admitted to the facility on [DATE].</p> <p>Review of MDS dated [DATE], included diagnoses of Alzheimer's disease, (a form of dementia causes a gradual decline in memory, thinking and reasoning skills), depression, and anxiety. Section O0300 Pneumococcal Vaccine indicated Resident R106 was not offered the pneumonia vaccination.</p> <p>Review of the clinical record failed to include documentation of that the pneumonia vaccination and education was provided to Resident R106.</p> <p>Review of the Admission Record indicated that Resident R112 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of MDS dated [DATE], included diagnoses of depression and high blood pressure. Section O0250 Influenza Vaccine indicated the resident was not offered the influenza vaccine in the facility. Section O0300 Pneumococcal Vaccine indicated Resident R112 was not administered the pneumonia vaccination, the reason was not indicated.</p> <p>Review of the clinical record failed to include documentation of that the influenza and pneumonia vaccination and education was provided to Resident R112.</p> <p>During an interview on 7/26/24 12:45 p.m. the Infection Preventionist Employee E9 confirmed that the facility failed to make certain that influenza and pneumococcal immunization was offered to four of five residents (Resident R53, R94, R106, and R112).</p> <p>28 Pa. Code 211.5(f) Clinical records</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to offering the COVID-19 vaccine and providing education for two of five residents reviewed for immunizations (Resident R53 and R106).</p> <p>Findings include:</p> <p>Review of the Centers for Disease Control (CDC) Staying Up to Date with COVID-19 Vaccines dated 7/3/24, indicated the CDC recommends the 2023-2024 updated COVID-19 vaccines-Pfizer-BioNTech, Moderna, or Novavax-to protect against serious illness from COVID-19. People aged [AGE] years and older who received 1 dose of any updated 2023-2024 COVID-19 vaccine (Pfizer-BioNTech, Moderna or Novavax) should receive 1 additional dose of an updated COVID-19 vaccine at least 4 months after the previous updated dose.</p> <p>Review of the Admission Record indicated that Resident R53 was admitted to the facility on [DATE].</p> <p>Review of Minimum Data Set (MDS-periodic assessment of care needs) dated 2/4/24, included diagnoses of a seizure disorder and high blood pressure.</p> <p>Review of the clinical record failed to include documentation of that the COVID vaccination and education was provided to Resident R53.</p> <p>Review of the Admission Record indicated that Resident R106 was admitted to the facility on [DATE].</p> <p>Review of MDS dated [DATE], included diagnoses of Alzheimer's disease, (a form of dementia causes a gradual decline in memory, thinking and reasoning skills), depression, and anxiety.</p> <p>Review of the clinical record failed to include documentation of that the COVID vaccination and education was provided to Resident R106.</p> <p>During an interview on 7/26/24 12:45 p.m. the Infection Preventionist Employee E9 confirmed that the facility failed to provide accurate and timely documentation related to offering the COVID-19 vaccine and providing education for two of five residents reviewed for immunizations (Resident R53 and R106).</p> <p>28 Pa. Code 211.5(f) Clinical records</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>48546</p> <p>Based on review of facility in-service documentation, personnel records, and staff interviews it was determined that the facility failed to implement and maintain an effective training program for three out of five personnel records (Nurse Aide (NA) Employee E25, NA Employee E26, and NA Employee E27).</p> <p>Findings include:</p> <p>Review of facility policy In-service Training dated 5/7/24, indicated that the facility will provide in-service training for all personnel on a regularly scheduled basis. All mandatory in-service requirements must be completed annually as a condition of continued employment. Training topics include effective communication, resident rights, abuse, neglect, and exploitation, quality assurance and performance improvement (QAPI), infection control, compliance and ethics, and behavioral health.</p> <p>Review of NA Employee E25's personnel record indicated a date of hire on 4/13/05. Review of NA Employee E25's personnel file did not include annual in-service training on effective communication, resident rights, abuse, QAPI, infection control, compliance and ethics, and behavioral health.</p> <p>Review of NA Employee E26's personnel record indicated a date of hire on 12/31/18. Review of NA Employee E26's personnel record did not include annual in-service training on resident rights, abuse, and compliance and ethics.</p> <p>Review of NA Employee E27's personnel record indicated a date of hire on 3/31/03. Review of NA Employee E27's personnel record did not include annual in-service training on effective communication and QAPI.</p> <p>During an interview on 7/26/24, at 9:55 a.m. Scheduler Employee E18 confirmed that the facility failed to implement and maintain an effective training program for three out of five personnel records as required.</p> <p>28 Pa. Code 201.18(b)(3) Management.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p>

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of facility policy, personnel files and staff interview it was determined that the facility failed to conduct the minimum 12 hours of nurse aide (NA) training per year for two of five NA personnel files (NA Employee E25 and E27) and failed to complete annual training on dementia management for one of five NA personnel files (NA Employee E25) and abuse prevention for two out of five NA personnel files were completed (NA Employee E25 and NA Employee E26).</p> <p>Findings include:</p> <p>Review of facility policy In-service Training dated 5/7/24, indicated that the facility will provide in-service training for all personnel on a regularly scheduled basis. All mandatory in-service requirements must be completed annually as a condition of continued employment. Training topics include dementia management and resident abuse prevention. The facility will ensure continuing competence for no less than 12 hours per year.</p> <p>Review of NA Employee E25's personnel record indicated she was hired to the facility on [DATE].</p> <p>Review of NA Employee E26's personnel record indicated she was hired to the facility on [DATE].</p> <p>Review of NA Employee E27's personnel record indicated he was hired to the facility on [DATE].</p> <p>Review of NA Employee E25's personnel record revealed zero hours of in-service education from 6/26/23 through 7/25/24.</p> <p>Review of NA Employee E27's personnel record revealed 11.39 hours of in-service education from 6/26/23 through 7/25/24.</p> <p>Review of annual in-service documentation and personnel records did not include an annual in-service training on dementia management for NA Employee E25.</p> <p>Review of annual in-service documentation and personnel records did not include an annual in-service training on resident abuse prevention for NA Employee E25 and NA Employee E26.</p> <p>During an interview on 7/26/24, at 9:55 a.m. Scheduler Employee E18 confirmed that the facility failed to conduct the minimum 12 hours of NA training per year, and failed to complete annual training on dementia management and abuse prevention as required.</p> <p>28 Pa. Code: 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code: 201.20(c) Staff Development.</p>		