| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395289 | A. Building<br>B. Wing | 02/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Wecare at South Hills Rehabilitation and Nrsg Ctr | 201 Village Drive<br>Canonsburg, PA 15317 |

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|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311<br><br>Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to make certain call light tubes were in reach for one of two residents with a breath activated call light response system (Resident R53).<br><br>Findings include:<br><br>The facility policy Call Light Response dated 10/23/24, indicated to ensure a call bell or alternative device will be accessible to each resident while in their room, toilet, or bathing area.<br><br>Review of Resident R53's clinical record indicated admission to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident R53's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/4/24, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), muscle weakness, and rheumatoid arthritis (chronic, painful inflammatory disorder affecting many joints, including those in the hands and feet). Review of Section GG: Functional Abilities, indicated that Resident R53 has range of motion impairment on both sides of her upper and lower body.<br><br>Review of a physician's note on 1/13/25, indicated Resident R53 was diagnosed with stiff person syndrome (rare neurological disorder characterized by progressive muscular rigidity and stiffness). The note further stated that Resident R53 has finger and hand contractures (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement).<br><br>Review of Resident R53's care plan last updated 1/15/25, failed to include a plan of care developed for complications of rheumatoid arthritis (other than pain), hand contractures, and the use of a breath activated call light system.<br><br>Review of Resident R53's Kardex (paper/electronic document that outlines the patients' activities of daily living, continence levels, and behaviors, as well as physician orders, advanced directives, diet, and allergies) as of 2/3/25, failed to include information related to a breath activated call light system.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a physician order dated 10/28/24, indicated, Resident unable to grip call bell, and other options failed to work due to resident condition, q 15-minute (every 15 minutes) safety checks.<br><br>Review of a physician order dated 11/21/24, indicated, Resident has a call light system that is activated by blowing into white tube. Sometimes forgets it is there. Please reinforce use to her when in room. A sign is in place on footboard per request to remind her how to activate call system.<br><br>Review of a progress note dated 10/28/24, at 2:44 p.m. indicated, Daughter notified of call bell unable to reach due to contractures, in hands bilaterally (both sides of the body), reviewed with daughter we have tried, head flat call bell, resident unable to move head, we are currently looking for the blow call and to see if it works on our system, as well we are currently having q 15-minute checks to ensure call bell placed in hand. and for safety.<br><br>During an interview and observation on 2/3/24, at approximately 10:45 a.m. Resident R53 asked the surveyor for assistance. The surveyor asked the resident if she had activated her call light, and the resident stated she I don't think I have one of those. At this time, a breath activated call light tube was noted to be at the level of the resident's face, on a flexible mount, but turned completely away from the resident.<br><br>On 2/3/24, the surveyor asked Registered Nurse (RN) Employee E2 for assistance with Resident R53, and she asked Nurse Aide (NA) Employee E6 to assist her. Upon entering the room, RN Employee E2 immediately repositioned the call light tube. NA Employee E6 stated, I don't even know how that thing works.<br><br>During an observation on 2/4/25, at approximately 11:00 a.m. Resident R53's call light tube was turned away from her face.<br><br>During an interview on 2/4/25, at approximately 11:02 p.m. NA Employee E7 confirmed that Resident R53's call light tube was turned away from her face, and she would be unable to activate it. NA Employee E7 confirmed that Resident R53 would call out if she needed assistance.<br><br>During an observation on 2/5/25, at approximately 1:50 p.m. Resident R53's call light tube was turned away from her face.<br><br>During an observation on 2/6/25, at approximately 12:30 p.m. Resident R53's call light tube was turned away from her face.<br><br>During an interview on 2/6/25, at approximately 12:33 p.m. NA Employee E7 confirmed that Resident R53's call light tube was turned away from her face, and she would be unable to activate it. When asked, NA Employee E7 confirmed she was unaware of the physician's order for checks every 15 minutes.<br><br>During an interview on 2/6/25, at approximately 3:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed facility failed to make certain call light tubes were in reach for one of two residents with a breath activated call light response system.<br><br>28 Pa. Code: 211.10(c)(d) Resident care policies.<br><br>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 28 Pa Code: 201.29 (l)(o) Resident rights. |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>49646<br><br>Based on review of resident council minutes, resident and group interviews and interviews with staff and facility policy, it was determined the facility failed to ensure the residents were offered a private group meeting during resident council for 10 of 10 residents interviewed (Resident R10, R19, R26, R31, R40, R43, R50, R52, R54, R56).<br><br>Finding include:<br><br>Review of the facility policy titled, Resident Council reviewed 10/23/24, states the facility will provide space, privacy and support to conduct meetings.<br><br>During Resident Group with ten alert and oriented residents on 2/5/25, at 1:00 p.m. Resident R10 and R43 indicated during resident council some of the members did not like to use their name if there was a concern or problem so the facility doesn't get told. Members of the resident council were asked , during the time they meet would it be more beneficial to meet in private than in the main dining room where staff and other residents continuously walk through and can hear the meeting going on, thus allowing residents to voice their concerns and the president can then take the concerns back to the facility. The President responded that Resident Council was always conducted with facility staff and other residents present, we never had it any other way. The residents that attended the group discussion were not aware they could have private meetings.<br><br>Interview with Activities Director and Director of Nursing on 2/5/25, at 2:04 p.m. indicated the facility was always invited to group meetings but confirmed the meetings were not held privately with only residents.<br><br>28 Pa. Code 201.29(a) Resident Rights |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311<br><br>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to notify resident representative and/or medical providers of a change in condition for two of six residents (Resident R29 and R62).<br><br>Findings include:<br><br>Review of the policy Health, Medical Condition and Treatment Options, Informing Resident Of, dated 10/23/24, indicated the responsible party or guardian is to be notified when there has been any change in condition, such as the diagnosis of an infection and the start of antibiotics.<br><br>Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:<br><br>13-15: cognitively intact<br><br>8-12: moderately impaired<br><br>0-7: severe impairment<br><br>Review of the clinical record indicated Resident R62 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident R62's MDS - a mandated assessment of a resident's abilities and care needs) dated 12/3/24, included diagnoses diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and a seizure disorder. Review of Section B: Hearing, Speech, and Vision indicated Resident R62's vision was impaired, hearing was severely impaired, and she had no speech. Review of Section C: Cognitive Patterns indicated Resident R62 had a BIMS score of 5.<br><br>Review of Resident R62's care plan initiated 5/2/24, indicated Resident R62 had impaired communication due to deafness, mutism, and legal blindness.<br><br>Review of a progress note dated 1/5/25, at 11:22 a.m. indicated, During care aide called this nurse into room, noted in resident brief large amount of bright red blood in brief. Resident's coccyx intact no skin integrity noted. Resident yelling out in pain. Notified hospice, hospice sending a nurse to come assess resident.<br><br>Further review of progress notes failed to reveal a communication to the resident representative or the medical provider.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a progress note dated 1/6/25, at 1:38 p.m. indicated, Resident is having emesis x3 (three instances of vomiting) today, BGM (blood glucose monitor) has been high, [Medical Provider] notified was order to give 10 extra of Lantus (a type of injectable medication to treat diabetes) and UA C&S (urinalysis with testing of bacterial growth) ordered.<br><br>Further review of progress notes failed to reveal a communication to the resident representative.<br><br>Review of a progress note dated 2/1/25, at 2:05 p.m. indicated, Resident had multiple emesis on 7-3 shift, VSS (vital signs stable) and afebrile (no fever).<br><br>Further review of progress notes failed to reveal a communication to the medical provider.<br><br>During an electronic communication on 2/7/24, at 11:03 a.m. the Director of Nursing confirmed there was not notification or follow-up to the above instances.<br><br>Review of the clinical record indicated that Resident R29 was admitted to the facility on [DATE], with diagnoses that included encephalopathy (disturbance of brain function that causes confusion, memory loss, and coma in severe cases), alcoholic cirrhosis (chronic liver disease caused by long-term, excessive alcohol consumption), depression and muscle weakness.<br><br>Review of the MDS dated [DATE], indicated diagnoses remained current and Section C Cognitive Patterns revealed resident had an updated BIMS score of 6, which indicated the resident has severe impairment.<br><br>In an interview with the Social Worker she states that a conversation occurred with the guardian that the resident has not been seen by a gynecologist recently and an appointment was scheduled for 1/21/25. Review of clinical records did not indicate that resident was sexually active or had any gynecological symptoms. During this routine exam the resident was diagnosed with Trichomoniasis (sexually transmitted infection) and started on an antibiotic on 2/1/25 to treat.<br><br>There was no evidence in the clinical record that the resident's guardian was notified of this change in condition. In a phone interview on 2/6/25, at approximately 10:30 a.m. with the guardian, it was the first that she was hearing that the resident had been diagnosed with a sexually transmitted infection.<br><br>During an interview on 2/6/25, at approximately 3:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to notify resident representative and/or medical providers of a change in condition for two of six residents.<br><br>28 Pa. Code 201.18 (b)(1) Management.<br><br>28 Pa. Code 201.29(d) Resident rights.<br><br>28 Pa. Code 211.10 (c)(d) Resident care policies.<br><br>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>39311<br><br>Based on observations and resident and staff interviews it was determined that the facility failed to provide a clean and homelike environment on one of two nursing units (A/E Nursing Unit) and for five of fourteen residents (Residents R15, R52, R53, R62, and R66).<br><br>Findings include:<br><br>During an observation on 2/3/25, at approximately 11:00 a.m., Resident R52's was noted to have trash on the floor, a drawer of the bedside table pulled out of the table and on its side, soiled washcloth and resident clothing on the floor, disposable cups and used gloves under the bed, and screws and a metal bracket on the windowsill. The foot board was removed from the bed and was lying on the floor in front of the wardrobe. The floor food residue adhered to it and dust and crumbs all over it.<br><br>During an observation on 2/4/25, at approximately 8:40 a.m., an Environmental Service (EVS) Worker was seen entering Resident R52's room and emptying the trash can. No other services were performed. Observation at this time revealed no significant change from the previous observation on 2/3/25.<br><br>During an interview on 2/4/25, at 8:47 a.m., Licensed Practical Nurse (LPN) Employee E6 was asked why Resident R52's room had not been cleaned. She stated that when EVS staff clean the room he pulls the clothes and drawers out again. Observation with LPN Employee E6 at this time confirmed the screws on the windowsill, the metal bracket, the tripping hazard of the footboard and other items on the floor, and the possibility that the food crumbs throughout the room would attract pests.<br><br>During an observation on 2/4/25, at approximately 11:30 a.m. Resident R52 room had the items removed from the floor, the drawer placed back into the bedside table, and the footboard placed between the wall and the side of the wardrobe. The floor appeared to have been somewhat swept, but a significant amount food resident was present, and the floor was not mopped.<br><br>During an observation on 2/6/24, at 12:03 p.m. a bag of what appeared to be trash, and a mop/broom handle was in the hall at the entrance to the A/E Nursing Unit.<br><br>During an observation on 2/6/24, at 12:04 p.m. of the shower room near the A/E Nursing Unit station revealed the commode blocked by two double-bin linen carts, two bedside commode receptacles with a brown substance in them, and an opened, gallon-sized container of bleach, accessible to residents.<br><br>During an observation on 2/6/24, at 12:15 p.m. the bathroom trash can for Residents R62 and R53 was overflowing onto the floor. Review of clinical residents revealed that neither resident was able to exit their bed and use the bathroom without staff assistance.<br><br>During an observation on 2/6/24, at 12:20 p.m. the floor of Residents R66 and R15 had a significant amount of trash and crumbs on the floor.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 2/6/25, at approximately 12:24 p.m., Resident R52's room floor was noted to be extremely soiled, food residue and crumbs present, one drawer of the three-drawer bedside table to be missing a handle, and one drawer of the four-drawer dresser to have a missing handle.<br><br>During an interview on 2/6/25 at approximately 3:30 p.m., the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to provide a clean and homelike environment on one of two nursing units and for five of fourteen residents.<br><br>28 Pa. Code: 207.2(a) Administrator's responsibility.<br><br>28 Pa. Code: 201.29(k) Resident rights. |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49646<br><br>Based on review of facility policy, clinical records, observations, and resident and staff interviews, it was determined the facility failed to ensure that one of 26 residents was free from sexual abuse that resulted in the actual harm of a newly diagnosed sexually transmitted infection for one of 26 residents (Resident R29).<br><br>Findings include:<br><br>A review of the facility policy titled Abuse and Neglect-Clinical Protocol, last reviewed 10/23/24, indicated that residents have the right to be free from abuse, as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, or causes physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Sexual Abuse is defined as non-consensual sexual contact of any type with a resident. The term Willful is used in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.<br><br>Additionally, the facility policy indicated that abuse prevention included assessing, care planning, cause identification, treatment/management and monitoring residents with needs and behaviors that may lead to conflict or neglect. Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues. The facility will strive to maintain adequate staffing on all shifts to ensure the needs of each resident are met.<br><br>Review of Resident R29's clinical record revealed admission to the facility on [DATE], with diagnoses that included encephalopathy (disturbance of brain function that causes confusion, memory loss, and coma in severe cases), alcoholic cirrhosis (chronic liver disease caused by long-term, excessive alcohol consumption), depression, muscle weakness.<br><br>Review of Resident R29's Minimum Data Set (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], section C Cognitive Patterns revealed severe cognitive impairment.<br><br>Review of the resident profile revealed Resident R29 has a court appointed guardian. In court appointed guardianship paperwork dated 12/21/21, it states that due to her diagnosis, Resident R29 suffers from permanent damage to her brain and recovery is not possible. Resident R29 is unable to receive or evaluate information or to communicate decisions to such an extent that she is unable to meet her essential requirement for her personal and financial needs. Resident R29 is in need of guardianship services and is totally incapacitated. There is no less restrictive alternative to the appointment of a Plenary Guardian and of the estate of Resident R29.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident R29's comprehensive person-centered care, plan of care that was initiated on 10/21/24, and revised on 1/22/25, does not mention the resident as having behaviors related to inappropriate sexual behaviors (making sexually inappropriate statements to caregivers, engaging in relationships with other residents,or desire to be sexually active or show sexual expression). No planned interventions are noted to manage sexual behaviors, monitor and document episodes of inappropriate behaviors and/or to notify physician/nurse-practitioner/physician assistant when behaviors persist.<br><br>During an interview on 2/6/25 at 3:18 p.m. Resident R29 revealed that she was in a relationship with Resident R67. She states they are engaged and plan to move in together when they both get out of the facility. When asked if they are sexually active she denied that they were.<br><br>Review of Resident R67's clinical record revealed admission to the facility on [DATE], with diagnoses that included schizoaffective disorder (combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder. Symptoms may occur at the same time or at different times), Alcohol use, muscle weakness, and depression.<br><br>Review of Resident R67's MDS assessment dated [DATE], section C Cognitive Patterns revealed Resident R67 had a BIMS score of 15, which indicated the resident is cognitively intact.<br><br>Review of clinical progress notes on 11/26/24, indicated Resident R67 was unhappy with increased sexual dysfunction secondary to his medication and asked his psychiatrist to change his medications to alleviate the sexual dysfunction.<br><br>Review of Resident R67's clinical record on 11/29/24, states the resident bought beer for a female resident because she had a migraine and she needed it. Resident R67 was given the explanation that he was not to buy alcohol for another resident and that if that resident needed alcohol it had to go through the physician.<br><br>During an interview on 2/5/25, at approximately 2:40 p.m. with the DON she stated that Resident R67 did buy the alcohol for Resident R29.<br><br>During an interview with Resident R67 on 2/6/25, at 2:44 p.m. he confirmed that he is in a relationship with Resident R29 and that they are engaged and his plan is to come back and visit her until she is able to be discharged and move in with him. Review of the clinical record reveals no documentation that Resident R67 is in a relationship with Resident R29.<br><br>Review of Resident R29's clinical record revealed the resident was diagnosed with Trichomoniasis(sexually transmitted infection causing a foul-smelling vaginal discharge, genital itching and painful urination in women, men typically have no symptoms). Resident R29 saw a gynecologist on 1/21/25, and office reported to facility on 1/31/ 25, that results from [NAME] test (Pap test-a cervical cancer screening procedure that involves taking a cell sample from the cervix, cells are examined then under a microscope) back positive for this infection and resident would need to start antibiotics to treat the infection.<br><br>During an interview with the gynecologist's office on 2/6/25, at approximately 10:30 a.m., revealed that Resident R29 stated she has been recently engaged in consensual intercourse. Resident also stated during this visit that she was engaged to a fell ow resident, Resident R67, and they plan to move in together.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident R29's clinical record failed to reveal documented evidence that social services, medical services or managerial staff followed up with the resident post-gynecological exam finding to determine the extent of relationship with Resident R67, and failed to reveal that her person-centered plan of care was reviewed and revised with new goals and approaches to manage her sexual behavior and resident-resident relationship.<br><br>Review of RN Employee E1 statement on 2/4/25 at 11:30 a.m. reported that she was notified on 1/31/25 that Resident R29 had Trichomoniasis but the facility felt that she came that way (transferred from hospital on 10/17/24), was aware that she was in a relationship with Resident R67, and there was concern that she might be pregnant due to abdomen being distended (no pregnancy test done at facility but at gynecological appointment on 1/21/25, the test was negative).<br><br>During an interview on 2/6/25 at 11:00 a.m. Resident R29's guardian stated she was aware that Resident R29 was in a relationship with another resident at the facility but she was not made aware of the new diagnosis of a sexually transmitted infection. Guardian stated she feels that Resident R29 does not have the capacity to differentiate what sexual intercourse entails, meaning is it kissing, oral sex, masturbation or intercourse or what the repercussions could be such as pregnancy (Resident R29 is still in child-bearing age with monthly menstruation) or a sexually transmitted infection.<br><br>During an interview on 2/6/25, at approximately 11:45 a.m. the Director of Nursing discussed Resident R29's behaviors as was noted from a previous facility, she was noted to be hypersexual in that she enjoyed flirting with the male residents and aides, talking in a sexual manner and she enjoyed sitting on men's laps, she had to be redirected of her behaviors at that facility and currently she is focused on her relationship with Resident R67. Resident R29 has never been care planned for these known hypersexual behaviors at her current facility.<br><br>During multiple interviews with multiple staff members (NA Employee's E5, E8, and E9) on 2/6/25, it was noted that Resident R29 and Resident R67 are together all the time, she sometimes goes into his room, they cuddle and watch movies together on his computer, they talk about moving in together, hug in the hallway, have been seen kissing. Staff stated that they had made management aware of the seriousness of the relationship.<br><br>During an interview with the Social Worker Employee E10 on 2/6/25, at 11:30 a.m, revealed that she was aware that Resident R29 and Resident R67 were friends but stated they feel Resident R29 is unable to make a decision to be in a committed relationship, Resident R67 can make that decision, they are engaged (did not mention he bought her an engagement ring), and spent time together in various areas of the facility but are never alone, also stated Resident R67 is due to be discharged soon and plans on returning to visit Resident R29.<br><br>Further review with DON and NHA confirmed the facility failed to ensure proper staff supervision of Resident R29 and Resident R67 and to develop and implement necessary interventions for a resident with a severe cognitive impairment from entering a relationship with a resident with cognitive impairment. The facility failed to develop and implement interventions after suspected sexual abuse occurred and to prevent further incidents of sexual abuse from occurring. This incident was identified as a harm for one of twenty-six residents.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee.<br><br>(continued on next page) |

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| | 395289 | A. Building<br>B. Wing | 02/10/2025 |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 28 Pa. Code 201.18(e)(1) Management.<br><br>28 Pa. Code 201.29(a)(c) Resident rights.<br><br>28 Pa. Code 211.12(c)(d)(5) Nursing services. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49646<br><br>Based on review of facility policy, clinical record review,facility submitted documents, and staff interview, it was determined that the facility failed to report an allegation of abuse in the required timeframe for one of nine residents (Resident R29).<br><br>Finding include:<br><br>Review of facility policy Abuse and Neglect dated 10/23/24, indicated abuse is the failure of the facility, its employees or service providers to provide goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. All allegations of abuse of unknown source must be reported immediately to the Administrator, Director of Nursing, and to the applicable State Agency. All serious incidents involving a resident will be reported to the Department of Health (State Agency) field office within 24 hours.<br><br>Review of the clinical record indicated Resident R29 was admitted to the facility on [DATE].<br><br>Review of Resident R29's Minimum Data Set (MDS-a periodic assessment of are needs) dated 11/14/24, indicated diagnoses of encephalopathy (disturbance of brain function that causes confusion, memory loss, and coma in severe cases), alcoholic cirrhosis (chronic liver disease caused by long-term, excessive alcohol consumption), depression and muscle weakness. Section C Cognitive Patterns revealed resident had an updated BIMS score (Brief Interview for Mental Status is a tool used to evaluate cognitive impairment and assist with dementia diagnosis) of 6, which indicated the resident has severe cognitive impairment.<br><br>During a review of the clinical record it was noted the resident had been recently diagnosed with Trichomoniasis (sexually transmitted infection causing a foul-smelling vaginal discharge, genital itching and painful urination in women, men typically have no symptoms) while at a routine gynecological exam. Interview with the gynecological office noted that the resident stated she had recently been in a consensual sexual relationship and was engaged to a fell ow resident. Resident has a low BIMS score and cognitively has issues with time and when she thinks something might have occurred, thus making her unreliable as to when the consensual intercourse might have occurred. During an interview with Resident R29 on 2/7/25, at 3:18 p.m. she discussed her relationship, denied that they were having intercourse but did state that he touches her leg (pointed to upper thigh) and they cuddle and kiss sometimes.<br><br>During an interview on 2/6/24, at approximately 3:30 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to report an allegation of abuse in the required timeframe for one of nine residents (Resident R29).<br><br>28 Pa. Code 201.14(a)(c)(e) Responsibility of licensee<br><br>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management<br><br>28 Pa. Code 201.20(b) Staff development<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 28 Pa. Code 211.10(c)(d) Resident care policies |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311<br><br>Based on a review of Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure that MDS assessments accurately reflected the resident's status for eight of sixteen residents (Resident R30, R43, R54, R56, R64, R66, R69, and R70).<br><br>Findings include:<br><br>The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS, mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions:<br><br>Coding Instructions O0300A, Is the Resident's Pneumococcal Vaccination Up to Date?<br><br>-Code 0, no: if the resident's pneumococcal vaccination status is not up to date or cannot be determined. Proceed to item O0300B, If Pneumococcal vaccine not received, state reason.<br><br>-Code 1, yes: if the resident's pneumococcal vaccination status is up to date. Skip to O0350, Resident's COVID-19 vaccination is up to date.<br><br>If the resident has not received a pneumococcal vaccine, code the reason from the following list:<br><br>-Code 1, Not eligible: if the resident is not eligible due to medical contraindications, including a life-threatening allergic reaction to the pneumococcal vaccine or any vaccine component(s) or a physician order not to immunize.<br><br>-Code 2, Offered and declined: resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the pneumococcal vaccine.<br><br>-Code 3, Not offered: resident or responsible party/legal guardian not offered the pneumococcal vaccine.<br><br>Review of Resident R30's Pneumococcal Vaccine Informed Consent form, dated 12/31/24, revealed Resident R30 refused to receive the pneumococcal vaccination.<br><br>Review of the MDS dated [DATE], indicated that Resident R30 was not offered the pneumococcal vaccine.<br><br>Review of Resident R43's Pneumococcal Vaccine Informed Consent/Declination form, dated 8/9/24, revealed Resident R43 consented to receive the pneumococcal vaccination.<br><br>Review of the MDS dated [DATE], indicated that Resident R43 was not offered the pneumococcal vaccine.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident R54's Pneumococcal Vaccine Informed Consent/Declination form, dated 1/2/23, revealed Resident R54 consented to receive the pneumococcal vaccination.<br><br>Review of the MDS dated [DATE], indicated that Resident R54 was not offered the pneumococcal vaccine.<br><br>Review of Resident R56's Pneumococcal Vaccine Informed Consent/Declination form, dated 12/11/24, revealed Resident R56 consented to receive the pneumococcal vaccination.<br><br>Review of the MDS dated [DATE], indicated that Resident R56 was not offered the pneumococcal vaccine.<br><br>Review of Resident R64's Pneumococcal Vaccine Informed Consent/Declination form, undated (remainder of admission packet dated 8/26/24), revealed Resident R64 consented to receive the pneumococcal vaccination.<br><br>Review of the MDS dated [DATE], indicated that Resident R64 was not offered the pneumococcal vaccine.<br><br>Review of Resident R66's Pneumococcal Vaccine Informed Consent/Declination form, dated 5/6/24, revealed Resident R64 refused to receive the pneumococcal vaccination.<br><br>Review of the MDS dated [DATE], indicated that Resident R66 was not offered the pneumococcal vaccine.<br><br>Review of Resident R69's Pneumococcal Vaccine Informed Consent/Declination form, undated (remainder of admission packet dated 10/8/24), revealed Resident R69 consented to receive the pneumococcal vaccination.<br><br>Review of the MDS dated [DATE], indicated that Resident R69 was not offered the pneumococcal vaccine.<br><br>Review of Resident R70's Pneumococcal Vaccine Informed Consent/Declination form dated 9/17/24, revealed Resident R70's resident representative consented for Resident R70 to receive the pneumococcal vaccination.<br><br>Review of the MDS dated [DATE], indicated that Resident R70 was not offered the pneumococcal vaccine.<br><br>During an interview on 2/6/24, at approximately 12:00 p.m. the Licensed Practical Nurse Assessment Coordinator Employee E3 confirmed that the MDS assessments were not completed accurately.<br><br>During an interview on 2/6/24, at approximately 3:30 pm. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to ensure that MDS assessments accurately reflected the resident's status for eight of fifteen residents.<br><br>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing Services. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311<br><br>Based on review of facility policies and documents, clinical records, and staff interviews, it was determined that the facility failed to provide care and services to possibly prevent hospitalization and failed to provide care and services after hospitalization for one of four residents (Resident R22).<br><br>Review of the clinical record indicated that Resident R22 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 1/16/25, included diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and heart failure (a progressive heart disease that affects pumping action of the heart muscles).<br><br>Review of Resident R22's weight record revealed the following:<br><br>04/03/24: 335.0 lbs. (pounds)<br><br>050/1/24: 322.0 lbs.<br><br>06/11/24: 325.0 lbs.<br><br>07/10/24: 378.2 lbs.<br><br>08/01/24: 324.5 lbs.<br><br>Review of Resident R22's progress notes revealed one documented attempt to reweigh the resident on 7/17/24.<br><br>Review of a progress note dated 7/27/24, at 11:30 a.m. indicated Resident R22 was transferred to the hospital due to abdominal pain, confusion, and increased blood pressure and heart rate.<br><br>Review of a progress note dated 7/27/24, at 6:05 p.m. indicated Resident R22 was admitted to the hospital with a diagnosis of exacerbation of CHF and was being given diuretics (medication to treat fluid buildup in the body by promoting excessive urination of the extra fluid).<br><br>Review of Resident R22's hospital documentation revealed<br><br>-Documentation indicated Resident R22 had shortness of breath for two days prior to hospitalization .<br><br>-Known history of diastolic CHF (congestive heart failure).<br><br>-Weight of 382 lbs. on 7/30/24.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Note dated 7/30/24, which indicated, She has diuresed well and urine output has been over 18L (18 liters, approximately 4.75 gallons) since her admission on 7/27/24.<br><br>-Included in the discharge paperwork was a blank daily weight log.<br><br>Review of a progress note dated 7/31/24, at 6:00 p.m. indicated Resident R22 returned to the facility after being hospitalized with acute on chronic diastolic heart failure.<br><br>Review of Resident R22's physician's orders after hospitalization failed to reveal any orders related to monitoring signs and symptoms of a CHF exacerbation such as fluid status, weight gain, swelling, or shortness of breath.<br><br>Review of Resident R22's physician's progress noted dated 8/14/24, failed to include information related to heart failure.<br><br>Review of Resident R22's plan of care last updated 1/15/25, failed to include a care plan developed for heart failure.<br><br>During an interview on 2/6/25, at approximately 3:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide care and services to possibly prevent hospitalization and failed to provide care and services after hospitalization for one of four residents.<br><br>28 Pa. Code: 201.18(b)(1) Management.<br><br>28 Pa. Code: 211.10(c)(d) Resident rights.<br><br>28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311<br><br>Based on observations and staff interview, it was determined that the facility failed to provide a safe environment for two of five residents ordered fall precautions (Resident R41 and R63) and on one of two nursing units (A/E Nursing Unit).<br><br>Findings include:<br><br>Review of the facility policy Falls - Clinical Protocol dated 10/23/24, indicated when a resident is found on the floor, the facility is obligated to investigate into how the resident got there and put into place an intervention to minimize it from recurring. This will be documented in the resident's care plan and progress notes.<br><br>Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 12/9/24, included diagnoses of a seizure disorder and history of a stroke.<br><br>Review of the fall assessment completed on 1/31/25, indicated Resident R41 was at medium risk for falls.<br><br>Review of a physician order dated 7/10/23, indicated Resident R41 was to have floor mats on both sides of the bed, when he is in bed.<br><br>During an observation on 2/3/25, at approximately 11:30 a.m. Resident R41 was observed to be in bed, with only a floor mat on his right side.<br><br>During an interview on 2/3/25, at approximately 11:30 a.m., Nurse Aide Employee E4 confirmed that Resident R41 was to have fall mats on both sides of his bed.<br><br>Review of the clinical record indicated Resident R63 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of the MDS dated [DATE], included diagnoses of Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior) and a seizure disorder. Review of Section G: Functional Abilities indicated Resident R63 required assistance to move from her wheelchair into bed.<br><br>Review of the fall assessment completed on 12/11/24, indicated Resident R63 was at high risk for falls.<br><br>Review of a physician order dated 10/3/24, indicated Resident R63 was to have floor mats when she is in bed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 2/6/24, at 12:15 p.m. of Resident R63 revealed her to be asleep in her bed. Both of her fall mats were observed to be folded and placed against the wall opposite her bed.<br><br>During an observation on 2/6/24, at 12:04 p.m. of the shower room near the Unit A/E nurses' station revealed an opened, gallon-sized container of bleach, accessible to residents.<br><br>During an observation on 2/6/24, at 12:12 p.m. of Resident R43's restroom revealed the cover to be missing from this baseboard heater, leaving the metal grill edges exposed.<br><br>During an observation on 2/6/24, at 12:20 p.m. of the Electricity Shutoff / Custodian Room it was observed that the door had a numeric keypad locking mechanism, but the door was not closed. Within the room, communication wiring was exposed, a bag of what appeared to be trash was on the floor, two unlocked housekeeping carts, a cleaning chemical mixing station above a floor-level mop sink, a mop bucket filled with a liquid, and multiple spray bottles of cleaning chemicals were accessible to residents.<br><br>During an interview on 2/6/25, at approximately 3:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide a safe environment for residents in one of two resident lounges/activity areas.<br><br>28 Pa. Code 201.18(e)(1) Management.<br><br>28 Pa. Code 201.20(a)(b) Staff development.<br><br>28 Pa. Code 201.29(a)(c)(d) Resident rights. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311<br><br>Based on review of facility policy, clinical record review, observations, and staff interview, it was determined that the facility failed to provide respiratory care/oxygen services consistent with professional standards of practice for one of four residents (Resident R22).<br><br>Findings include:<br><br>Review of facility policy, titled Oxygen Administration, with a review date of 10/23/24, purpose is to improve oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. This includes verification of a physician order for use of device, regulator checking equipment and periodic assessment.<br><br>The Resident Assessment Instrument (RAI) User Manual, which gives instructions for completing Minimum Data Set assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that Section O: Special Treatments, Procedures, and Programs, Non-invasive Mechanical Ventilator (BiPAP/CPAP) should be checked if the resident utilized a BiPAP or CPAP after admission/entry or reentry to the facility and within the 14-day look-back period.<br><br>-O0110G1, Non-invasive Mechanical Ventilator: Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing<br><br>by delivering slightly pressurized air through a mask or other device continuously or via<br><br>electronic cycling throughout the breathing cycle<br><br>-O0110G2, BiPAP: Check if the non-invasive mechanical ventilator support was BiPAP.<br><br>-O0110G3, CPAP: Check if the non-invasive mechanical ventilator support was CPAP.<br><br>Review of the clinical record indicated that Resident R22 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 1/16/25, included diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and heart failure (a progressive heart disease that affects pumping action of the heart muscles). This assessment did not include a diagnosis of obstructive sleep apnea (disorder that causes breathing to repeatedly stop and start during sleep).<br><br>Review of the facility diagnosis list did not include a diagnosis of obstructive sleep apnea.<br><br>Review of a progress note dated 4/3/24, at 5:31 p.m. indicated, Resident R22 returned from the hospital, with a new order for a BiPAP machine.<br><br>(continued on next page) |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a facility provided delivery ticket revealed a BiPAP was delivered to the facility on [DATE].<br><br>Review of MDS assessments dated 6/19/24, 8/7/24, 11/7/24, did not indicate BiPAP usage.<br><br>Review of hospital paperwork dated 7/31/24, indicated Resident R22 had a diagnosis of obstructive sleep apnea.<br><br>Review of Resident R22's physician orders since 4/3/247, did not include an order to provide BiPAP services until 7/31/24.<br><br>Review of Resident R22's care plan last reviewed 1/15/25, did not include information related to BiPAP usage until 8/1/24.<br><br>During an interview on 2/6/25, at approximately 1:00 p.m. the Licensed Practical Nurse Assessment Coordinator confirmed that Resident R22's BiPAP usage was not captured until the MDS of 1/16/25.<br><br>During an interview of 2/6/25, at approximately 3:30 p.m. the Director of Nursing confirmed that an order for BiPAP usage was not in place and Resident R22's care plan was not updated until approximately four months after Resident R22 began using a BiPAP.<br><br>During an interview on 2/6/25, at approximately 3:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide respiratory care/oxygen services consistent with professional standards of practice for one of four residents.<br><br>28 Pa. Code: 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395289 | A. Building<br>B. Wing | 02/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>39311<br><br>Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to make certain that medications and biologicals were properly disposed of in one of two medication rooms (Units B/C medication room).<br><br>Findings include:<br><br>Review of the facility policy Storage of Medications dated 10/23/24, indicated that discontinued, outdated, or deteriorated drugs are returned to the dispensing pharmacy or destroyed.<br><br>During an observation of the Units B/C medication room medication room on 2/3/25, at approximately 11:30 a.m. four opened, partially used bottles of acetic acid solution (a type of antiseptic), with open dates of 1/22/25, 1/25/25, 1/31/25, and 2/1/25 were observed. On each of the bottles was a pre-printed pharmacy label that read: **BOTTLE EXPIRES 24 HOURS AFTER OPENING**.<br><br>During an interview on 2/3/25, at 2:36 p.m. Registered Nurse Employee E2 confirmed the above observations.<br><br>During an interview on 2/6/25, at approximately 3:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to make certain that medications and biologicals were properly disposed of in one of two medication rooms.<br><br>28 Pa. Code: 201.14 (a) Responsibility of licensee.<br><br>28 Pa. Code: 201.18 (b)(1)(e)(1) Management.<br><br>28 Pa. Code: 211.9 (a)(1) Pharmacy services.<br><br>28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311<br><br>Based on facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain residents who requested the pneumococcal vaccine were provided the vaccination for six of seven residents (Resident R43, R54, R56, R64, R69, and R70).<br><br>Findings include:<br><br>Review of the facility policy Pneumococcal Vaccination dated 10/23/24, previously reviewed 1/18/24, indicated all residents are offered the pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.<br><br>Review of the Admission Record indicated that Resident R43 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident R43's Pneumococcal Vaccine Informed Consent/Declination form, dated 8/9/24, revealed Resident R43 consented to receive the pneumococcal vaccination.<br><br>Review of Resident R43's clinical record failed to reveal the pneumococcal vaccine was provided.<br><br>Review of the Admission Record indicated that Resident R54 was admitted to the facility on [DATE].<br><br>Review of Resident R54's Pneumococcal Vaccine Informed Consent/Declination form, dated 1/2/23, revealed Resident R54 consented to receive the pneumococcal vaccination.<br><br>Review of Resident R54's clinical record failed to reveal the pneumococcal vaccine was provided.<br><br>Review of the Admission Record indicated that Resident R56 was admitted to the facility on [DATE].<br><br>Review of Resident R56's Pneumococcal Vaccine Informed Consent/Declination form, dated 12/11/24, revealed Resident R56 consented to receive the pneumococcal vaccination.<br><br>Review of Resident R56's clinical record failed to reveal the pneumococcal vaccine was provided.<br><br>Review of the Admission Record indicated that Resident R64 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident R64's Pneumococcal Vaccine Informed Consent/Declination form, undated (remainder of admission packet dated 8/26/24), revealed Resident R64 consented to receive the pneumococcal vaccination.<br><br>Review of Resident R64's clinical record failed to reveal the pneumococcal vaccine was provided.<br><br>Review of the Admission Record indicated that Resident R69 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident R69's Pneumococcal Vaccine Informed Consent/Declination form, undated (remainder of admission packet dated 10/8/24), revealed Resident R69 consented to receive the pneumococcal vaccination.<br><br>Review of Resident R69's clinical record failed to reveal the pneumococcal vaccine was provided.<br><br>Review of the Admission Record indicated that Resident R70 was admitted to the facility on [DATE].<br><br>Review of Resident R70's Pneumococcal Vaccine Informed Consent/Declination form dated 9/17/24, revealed Resident R70's resident representative consented for Resident R70 to receive the pneumococcal vaccination.<br><br>Review of Resident R70's clinical record failed to reveal the pneumococcal vaccine was provided.<br><br>During an interview on 2/6/25, at 2:27 p.m. Infection Preventionist Registered Nurse Employee E1 confirmed the above residents did not receive the pneumococcal vaccination.<br><br>During an interview on 2/6/25, at approximately 3:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to make certain residents who requested the pneumococcal vaccine were provided the vaccination for six of seven residents.<br><br>28 Pa. Code 211.5(f) Clinical records. |