

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Corner View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6655 Frankstown Avenue Pittsburgh, PA 15206	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility policies, observations, and resident and staff interviews, it was determined that the facility failed to determine the ability to safely self-administer medications for two of six residents reviewed (Resident R143, and R318).</p> <p>Findings include:</p> <p>Review of the facility's policy Self-Administration of Medication last reviewed 2/3/25, indicated residents have the right to self-administer medications if the interdisciplinary team has determined it is clinically appropriate and safe for the resident to do so. The staff and practitioner will document their findings and the choices of residents who are able to self-administer medications.</p> <p>Review of the admission record indicated Resident R143 was admitted to the facility on [DATE].</p> <p>Review of Resident R143's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/5/24, indicated the diagnoses of Non-Alzheimer's Dementia (dementia caused by other diseases with symptoms forgetfulness, limited social skills, and impaired thinking abilities that interfere with daily functioning), seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness), and schizophrenia (characterized by thoughts or experiences that seem out of touch with reality, disorganized speech or behaviors, and decreased participation in activities of daily living).</p> <p>Review of Resident R143's physician orders dated 2/1/25, indicated lactulose (medication that treats liver disease) 30 mls (milliliters) twice daily for treatment of cirrhosis of the liver (diseased liver), and failed to indicate an order for self-administration of medications.</p> <p>Review of Resident R143's care plan dated 1/14/24, indicated to give medications as ordered, and failed to include a goal or interventions for self-administration of medications.</p> <p>Review of assessments indicated that an assessment to safely self-administer medications was not completed.</p> <p>Observations of Resident R143's overbed table on 2/3/25, at 9:29 a.m. revealed a medication cup filled with a green liquid.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 2/3/24, at 9:45 a.m. Licensed Practical Nurse (LPN) Employee E7 confirmed the medication cup was Resident R143's lactulose.</p> <p>Review of the admission record indicated Resident R318 was admitted to the facility on [DATE].</p> <p>Review of Resident R318's MDS dated [DATE], indicated the diagnoses of high blood pressure, atrial fibrillation (irregular heart rhythm), and heart failure (heart doesn't pump blood as well as it should).</p> <p>Review of Resident R318's physician orders dated 1/16/25, indicated albuterol (medication to assist in breathing) aerosol two puffs every four hours as needed for wheezing, and failed to indicate an order for self-administration of medications.</p> <p>Review of Resident R318's care plan dated 1/22/25, indicated to give aerosol or bronchodilators (relaxes muscles in the airway making it easier to breathe) as ordered, and failed to include a goal or interventions for self-administration of medications.</p> <p>Review of assessments indicated that an assessment to safely self-administer medications was not completed.</p> <p>Observations of Resident R318's overbed table on 2/3/25, at 9:32 a.m. revealed an albuterol inhaler on resident's nightstand.</p> <p>Interview on 2/3/24, at 9:45 a.m. Licensed Practical Nurse (LPN) Employee E7 confirmed the albuterol inhaler was sitting on resident's nightstand.</p> <p>Interview on 2/3/25, at 2:00 p.m. the Director of Nursing, confirmed the facility failed to determine the ability to safely self-administer medications for two of six residents reviewed (Resident R143, and R318).</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0570</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Assure the security of all personal funds of residents deposited with the facility.</p> <p>27424</p> <p>Based on review of facility documentation and staff interviews it was determined that the facility failed to ensure that the surety bond had sufficient funds to cover the residents personal funds for three of three months (November 2024, December 2024, and January 2025).</p> <p>Findings include:</p> <p>Review of facility bank statements indicated:</p> <p>November 2024 - \$409,305.82</p> <p>December 2024 - \$406,090.88</p> <p>January 2025 - \$405,479.42</p> <p>Review of facility surety bond indicates the amount covered equaled\$300,000.</p> <p>During an interview on 2/6/25, at 11:31 a.m. Regional Business Office Manger confirmed that the facility failed to ensure that the surety bond covered the resident trust fund for November 2024, December 2024 and January 2025.</p> <p>28 Pa.Code 201.14(a)Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(2)Management.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>27424</p> <p>Based on policy, resident and staff interview interviews, and observations it was determined that the facility failed to make certain the grievance policy was posted prominently throughout the facility, failed to include an anonymous place and the address, email and phone number for the grievance officer for 5 of 5 nursing units.</p> <p>Findings include:</p> <p>S483.10(j) Grievances.</p> <p>S483.10(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance.</p> <p>Review of facility policy Filing Grievances/Complaints dated 2/3/25, indicated Our facility will help residents, their representatives (sponsors), other interested family members, or resident advocates file grievances or complaints when such requests are made.</p> <p>Resident group on 2/4/25, at 10:30 a.m. indicated they were unaware of the grievance policy and procedure and how to file anonymously.</p> <p>During observations on 2/6/25, from 1:05 p.m. to 1:38 p.m. on second floor nursing unit to sixth floor nursing unit failed to include the grievance policy posted throughout the facility, failed to include how and where an anonymous place to file grievances were located. The posting for grievance failed to include the business address, email, and phone number.</p> <p>During an interview on 2/7/25, at 11:44 a.m. Director of Social Services Employee E8 confirmed that the facility failed to make certain that the grievance policy was posted prominently throughout the facility failed to include an anonymous place for grievances, failed to include all the required information to include address, email and phone number for grievance officer.</p> <p>28 Pa. Code 201.29(1)Resident rights.</p> <p>28 P. Code 201.18 (e)(4)Management.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on review of facility policy, clinical record review and staff interview, it was determined that the facility failed to fully investigate an incident to eliminate possible abuse or neglect for one of three residents (Resident R24).</p> <p>Findings include:</p> <p>Review of the facility policy Abuse Investigation and Reporting reviewed 1/15/24, indicated if an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the administrator will assign the investigation to an appropriate individual. The investigation must include interviews of any witnesses to the incident, the resident's roommate, family, and staff members on all shifts who have had contact with the resident during the period of the alleged incident. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it.</p> <p>Review of the facility policy Assessing Falls and Their Causes reviewed 1/15/24, indicated falls are a leading cause of morbidity and mortality among the elderly in nursing homes. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing.</p> <p>A review of the clinical record indicated Resident R24 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses that included high blood pressure, dislocation of right shoulder joint, and diabetes.</p> <p>Review of Residents R24's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/11/24, indicated diagnoses were current. Section GG- Functional Abilities GG0170. Mobility indicated the resident was dependent with the ability to roll from lying on back to left and right side, and return to lying on back of bed.</p> <p>A review of facility records indicated on 1/28/25, Resident R24 was turned on her side with an assist of one person, left unattended, and fell out of bed. The facility failed to provide evidence post-fall monitoring occurred as required. Resident R24 was found unresponsive on 1/29/25, and ceased to breathe at 5:41 a.m. The facility failed to investigate the incident to eliminate possible abuse or neglect. The facility failed to obtain any statements that were both signed and dated by the witnesses. No information was provided for Resident R24's roommate or LPN, Employee E5 who was the nurse assigned to her care from 11:00 p.m. on 1/28/25, until 7:00 a.m. on 1/29/25. The incident was not fully investigated to rule out abuse or neglect.</p> <p>During an interview on 2/4/25, at 11:33 a.m. the Nursing Home Administrator confirmed Resident R24's incident was not fully investigated, and the facility failed to obtain statements that were both signed and dated by the witness.</p> <p>28 Pa. Code: 201.149(a) Responsibility of licensee.</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>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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of clinical records and staff interviews, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three of six residents sampled with facility-initiated transfers (Residents R80, R105 and R124).</p> <p>Findings include:</p> <p>Review of the facility policy Transfer or Discharge, Facility-Initiated reviewed 1/15/24, and again on 2/3/25, indicated information conveyed to receiving provider, and documentation of transfer to include 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 R80 was admitted to the facility on [DATE].</p> <p>Review of Resident R80's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/13/25, indicated diagnosis of hypertension (high blood pressure), hyperlipidemia (high fat in the blood) and aphasia (loss of ability to understand or express speech).</p> <p>Review of Resident R80's clinical record revealed that the resident was transferred to the hospital on 1/3/25.</p> <p>Review of Resident R80's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the resident 's transfer, 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 R105 was admitted to the facility on [DATE].</p> <p>Review of Resident R105's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/9/25, indicated diagnoses of anxiety (intense, excessive, and persistent worry and fear about everyday situations), bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and depression.</p> <p>Review of Resident R105's clinical record revealed that the resident was transferred to the hospital on 1/29/25.</p> <p>Review of Resident R105's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transfer, 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>(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 the clinical record indicated Resident R124 was admitted to the facility on [DATE].</p> <p>Review of Resident R124's MDS dated [DATE], indicated diagnoses of high blood pressure, stroke (damage to the brain from an interruption of blood supply), and hemiplegia (paralysis of one side of the body).</p> <p>Review of Resident 124's clinical record revealed that the resident was transferred to the hospital on 9/27/24.</p> <p>Review of Resident R124's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transfer, 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>Interview on 2/7/25, at 9:33 a.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three of six residents sampled with facility-initiated transfers (Residents R80, R105 and R124).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(a)(b)(3) Management.</p> <p>28 Pa. Code: 201.29(b)(d)(j) Resident rights.</p> <p>28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility policy, clinical records and staff interviews it was determined that the facility failed to make certain that resident assessments were accurate for four of 12 residents (Residents R51, R90, R117, and R164).</p> <p>Findings include:</p> <p>The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of resident care needs), dated October 2024, indicated that Section C: Cognitive Patterns, Question C0100 Should Brief Interview for Mental Status Be Conducted? (BIMS) should be coded as 0 if the resident is rarely/never understood, and that it should be coded 1, and the BIMS assessment should be completed if the resident is at least sometimes understood.</p> <p>Further review of the RAI indicated under Coding Tips rules for stopping the BIMS before it is complete:</p> <ol style="list-style-type: none"> 1. All responses up to this point have been nonsensical (making no sense), 2. there has been no verbal or written response to any of the questions up to this point, or 3. there has been no verbal or written response to some questions up to this point <p>and for all others, the resident has given a nonsensical response.</p> <p>The remaining questions would be filled out with a dash (-).</p> <p>The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of resident care needs), dated October 2024, indicated that Section K: Swallowing/Nutrition Status, Question K0300, Weight loss, Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. In cases where a resident has a weight loss of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K0300 can be coded as 1.</p> <p>Review of the admission record indicated Resident R51 was admitted to the facility on [DATE].</p> <p>Review of Resident R51's MDS dated [DATE], indicated the diagnoses of anxiety (repeated episodes of sudden feelings of intense anxiety and fear or terror), schizophrenia (is a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness and social interactions), and depression (mood disorder that causes persistent feelings of sadness and loss of interest). Section C- Cognitive Patterns, Question C0100 indicated that Resident R51 should receive a BIMS interview. Section C had dashes entered for the remainder of the interview questions.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 2/6/25, at 9:06 a.m. Director of Social Services Employee E8 confirmed that the facility failed to certain that Resident R51 MDS assessment was accurate.</p> <p>Review of the admission record indicated Resident R90 was admitted to the facility on [DATE].</p> <p>Review of Resident R90's MDS dated [DATE], indicated the diagnoses of high blood pressure, arthritis, and osteoporosis (a condition in which bones become weak and brittle). Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R90 understands and can be understood. Section C: Cognitive Patterns, Question C0100 indicated that Resident R90 should receive a BIMS interview. Section C had dashes entered for the remainder of the interview questions.</p> <p>Review of the admission record indicated Resident R117 was admitted to the facility on [DATE].</p> <p>Review of Resident R117's MDS dated [DATE], indicated the diagnosis of hypertension (high blood pressure), diabetes (high sugar in the blood) and hyperlipidemia (high fat in the blood). Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R117 usually understood and usually understands. Section C: Cognitive Patterns, Question C0100 indicated that Resident R117 should receive a BIMS interview. Section C had dashes entered for the remainder of the interview questions.</p> <p>Interview on 02/06/25, at 8:54 a.m. with Director of Social Services Employee E8 indicated I do not assess, as an example, when they are sleeping. I don't fill it in. Should I be doing it another way?</p> <p>Review of admission record indicated that Resident R164 was admitted to the facility 12/27/24.</p> <p>Review of Resident R164's MDS dated [DATE], indicated the diagnoses necrotizing fasciitis (serious bacterial infection that results in the death of the body's soft tissue), high blood pressure, and protein-calorie malnutrition. Section K, Question 0200, Height and Weight, indicate that a Height of 72 inches, and weight of 133 pounds; Question K0300, Weight loss, was coded 1. Yes, on physician-prescribed weight-loss regimen.</p> <p>Review of clinical record indicated that Resident R164 weight as documented on 12/28/24, was 132.8 pounds. No additional weights were available for comparison based on criteria from RAI manual.</p> <p>Review of clinical physician progress notes failed to indicate documentation that Resident R164 was on a physician-prescribed weight-loss regimen.</p> <p>Review of clinical nutrition progress notes failed to indicate documentation that Resident R164 was on a physician-prescribed weight-loss regimen.</p> <p>During an interview on 2/5/25, at 1:50 p.m., Registered Dietitian (RD) Employee E21 revealed that Resident R164 did not have significant weight loss and was not on a physician-prescribed weight-lose regimen. RD Employee E21 revealed that MDS information was entered in error.</p> <p>During an interview on 2/5/25, at 3:00 p.m., Registered Nurse Assessment Coordinator (RNAC) Employee E22 confirmed that Section K, Question 0300, Weight loss was entered in error.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 2/6/25, at 3:00 p.m. the [NAME] President of Clinical Services Employee E9 confirmed the facility failed to make certain that resident assessments were accurate for four of 12 residents (Residents R64, R90, R117, and R164).</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.5(f) Clinical Records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on review of facility policies, and clinical records, facility documents, as well as staff interviews, it was determined that the facility failed to ensure documentation was timely entered for a resident after an unwitnessed fall occurred for one of three residents (Resident R24).</p> <p>Findings include:</p> <p>Review of the facility policy Charting and Documentation reviewed 1/15/24, indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident ' s medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.</p> <p>Review of the facility policy Change in a Resident's Condition or Status last reviewed 1/15/24, indicated the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p> <p>Review of Residents R24's admission record indicated she was admitted on [DATE], and readmitted [DATE].</p> <p>Review of Residents R24's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/11/24, indicated diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), and dementia (a decline in cognitive functions such as memory, reasoning, and communication, significantly affecting daily life).</p> <p>Review of Resident R24's incident report dated 1/28/25, at 6:00 p.m. completed by Registered Nurse, Employee E1 indicated Resident R24 had an unwitnessed fall.</p> <p>Review of a late entry progress note entered by RN, Employee E1 on 1/29/25, at 5:51 a.m. effective 1/28/25, at 6:00 p.m. stated she was called to unit due the resident falling on floor. The nurse on the unit stated she was turned on her side for comfort to poop and rolled onto floor by accident. Resident denied pain, dizziness or injury. Denies hitting anything upon falling. Vitals stable within normal limits. Care plan to continue. The note was entered after the resident's time of death was called at 5:41 a.m.</p> <p>Review of a late entry progress note entered by Licensed Practical Nurse, Employee E2 on 1/29/25, at 9:55 a.m. effective 1/29/25, at 9:39 a.m. stated this nurse was sitting at nurses' station when I heard someone yelling for help. Nurse Aide went in room, turned around and stated, resident is on the floor. This nurse went room and found resident laying on her left side parallel to left of bed. 3-11 Supervisor made aware. The note was entered after the resident's time of death was called at 5:41 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a late entry progress note entered by RN, Employee E1 on 1/29/25, at 9:41 a.m. effective 1/28/25, at 6:00 p.m. stated RN called to floor by unit nurse for a report of resident falling onto floor. When RN arrived, resident was on the floor being assisted by two nurse aides with a hooyer lift back to bed. Fall was unwitnessed by staff. The note was entered after the resident's time of death was called at 5:41 a.m.</p> <p>Review of a late entry progress note entered by LPN, Employee E2 on 1/29/25, at 9:58 a.m. effective 1/29/25, at 9:56 a.m. stated This nurse went to check on resident before leaving for the night. Resident was alert and verbal. Resident denied any pain or discomfort. The note was entered after the resident's time of death was called at 5:41 a.m.</p> <p>Review of a late entry progress note entered by LPN, Employee E5 on 1/30/25, at 7:03 a.m. effective 1/29/25, at 6:51 a.m. stated Resident is alert and oriented, denies any pain or discomfort. Resident refused vital signs informed resident vital would be done in the morning. Observed resident three times throughout the night. In the morning found resident absent of all signs. The note was entered after the resident's time of death was called at 5:41 a.m.</p> <p>During an interview on 2/4/25, at 10:11 a.m. RN, Employee E1 stated if a resident falls, a nurse must complete an assessment, obtain vitals, and document right away in risk management and progress notes. RN, Employee E1 confirmed she failed to ensure documentation was timely entered for Resident R24 after an unwitnessed fall occurred.</p> <p>During an interview on 2/4/25, at 10:50 a.m. LPN, Employee E2 stated she left the facility around 11:00 p.m. on 1/28/25, and was made aware Resident R24 ceased to breathe on the morning of 1/29/25. LPN, Employee E2 confirmed she failed to ensure documentation was timely entered for Resident R24 after an unwitnessed fall occurred.</p> <p>During an interview on 2/4/25, at 11:33 a.m. the Nursing Home Administrator confirmed the facility failed to ensure documentation was timely entered for a resident after an unwitnessed fall occurred for one of three residents (Resident R24).</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on a review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to assess, document, and notify physicians of an abnormal Capillary Blood Glucose (CBG) levels for one of four residents reviewed (Resident R134), and failed to appropriately respond to a resident's change in condition for one of four residents (Resident R368).</p> <p>Findings include:</p> <p>Review of facility policy Obtaining a Fingerstick Glucose Level reviewed 1/15/24, indicated that the procedure is to obtain a blood sample to determine the resident's blood glucose level. The person performing this procedure should record the following information in the resident's medical record:</p> <ol style="list-style-type: none"> 1. The date and time the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 3. All assessment data obtained during the procedure. 4. If the resident refused the procedure, the reason(s) why and the intervention taken. 5. The blood sugar result. Follow facility policies and procedures for appropriate nursing interventions regarding blood sugar results (if resident is on sliding scale coverage, and/or physician intervention is needed to adjust insulin or oral medication dosage), etc. 6. The signature and title of the person recording the data. <p>The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it's untreated for long periods of time, you can damage your nerves, blood vessels, tissues, and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy Skin Integrity-Skin Tears reviewed 1/15/24, indicated it is the policy of the facility to provide proper treatment and care to maintain skin integrity. Licensed nurses will conduct skin assessments in accordance with facility policy. When a skin tear is discovered, the attending physician will be notified.</p> <p>Review of the facility policy Change in a Resident's Condition or Status last reviewed 1/15/24, indicated the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p> <p>Review of the clinical record indicated Resident R134 was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 1/8/25, indicated diagnoses of chronic obstructive pulmonary disease, chronic kidney disease, and diabetes mellitus (metabolic disorder in which the body has high sugar levels for prolonged periods of time).</p> <p>Review of Resident R134 physician order dated 12/13/24, indicated to administer Humalog KwikPen Subcutaneous Solution Peninjector 100 unit/ml [milliliter] (Insulin Lispro [a short acting, manmade version of human insulin]) Inject as per sliding scale: if 70 - 140 = 0; 141 - 180 = 1; 181 - 220 = 2; 221 - 260 = 3; 261 - 300 = 4; 301 - 340 = 5; 341 - 999 = 6 and call MD, subcutaneously before meals.</p> <p>Review of Resident R134's care plan dated 1/30/25, indicated Diabetes medication as order by doctor. Monitor/document for side effects and effectiveness. Monitor/document/report as needed any signs or symptoms of hyperglycemia.</p> <p>Review of Resident R134's eMAR (electronic Medication Administration Record) revealed that the resident's CBG's were as follows:</p> <p>On 1/28/25, at 8:29 p.m., the CBG was noted to be 500.</p> <p>Review of Resident R134's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, staff failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed date.</p> <p>During an interview on 2/6/25, at 10:00 a.m., the [NAME] President of Clinical Services Employee E9 confirmed that the facility failed to assess, document, and notify physicians of an abnormal Capillary Blood Glucose (CBG) levels for one of four residents reviewed (Resident R134)</p> <p>Review of the clinical record indicated Resident R368 was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 11/20/24, included diagnoses of high blood pressure, lymphedema (condition that results in swelling of the leg or arm), and an acquired absence of left leg below the knee.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R368's progress note dated 11/29/24, indicated the resident went out for a family visit on Thanksgiving and fell at a family member's house. An open area to the right knee area was observed. Review of the clinical record failed to indicate an assessment of Resident R368's right knee wound or that the doctor was notified.</p> <p>Review of Resident R368's Nursing-Weekly Skin Evaluation dated 12/5/24, indicated the resident had a left lower leg skin tear. The facility failed to identify the correct anatomical position of the resident's right knee wound and provide a description including measurements.</p> <p>Review of Resident R368's clinical record revealed a progress note dated 12/11/24, that indicated the resident was seen for follow up and management of the resident's wounds. It was indicated Certified Physician Assistant, Employee E16 spoke with the resident's family member who was concerned about the resident's knee wound from when he fell on Thanksgiving. The resident had a full thickness trauma wound that measured 3 centimeters (cm) x 3 cm x 0.1 cm. It was indicated there was a scant amount of drainage noted and the wound bed was covered with 76-100% slough.</p> <p>Review of Resident R368's physician order dated 12/12/24, indicated to cleanse the right knee wound with normal saline (solution used to cleanse and irrigate wounds), apply medi honey (wound and burn gel that assists in wound healing and has antibacterial and bacterial resistant properties), and cover with a dry dressing every day shift. The facility failed to obtain a physician order for Resident R368's right knee wound for a total of 14 days.</p> <p>Review of Resident R368's clinical record on 2/5/25, at 10:18 a.m. failed to include an assessment of Resident R368's right knee wound that included a description and measurement of Resident R368's right knee wound from 11/29/24, through 12/10/24. A total of 13 days.</p> <p>During an interview on 2/5/25, at 11:26 a.m. the [NAME] President of Clinical Services, Employee E9 confirmed the facility to timely notify a physician, assess and obtain orders for Resident R368's right knee wound.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 201.29(a) Resident rights.</p> <p>28 Pa. Code: 201.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on facility policy, observation, clinical record review, and staff interview, it was determined that the facility failed to provide treatment and services to prevent further decrease in range of motion for five of seven residents (Residents R15, R22, R43, R45, and R50).</p> <p>Findings include:</p> <p>Review of the facility policy Assistive Devices and Equipment dated 2/3/25, indicated the facility maintains and supervised the use of assistive devices and equipment for residents. Staff are trained and demonstrate competency on the use of devices and equipment prior to assisting or supervising residents.</p> <p>Review of the admission record indicated R15 was admitted to the facility on [DATE].</p> <p>Review of Resident R15's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/31/24, indicated the diagnoses of stroke (damage to the brain from an interruption of blood supply), anemia (the blood doesn't have enough healthy red blood cells), and atrial fibrillation (irregular heart rhythm).</p> <p>Review of Resident R15's physician order dated 12/20/24, indicated wear left palm guard (splint that positions the fingers away from the palm to protect the skin from moisture, pressure, and nail puncture) with finger separators three to four hours daily during daylight shift as tolerated by the resident. Remove for care and check skin integrity before and after putting on and taking off palm guard.</p> <p>Review of Resident R15's care plan dated 2/3/25, indicated wear left palm guard with finger separators three to four hours daily during daylight shift as tolerated by the resident. Remove for care and check skin integrity before and after putting on and taking off palm guard.</p> <p>Observations on 2/3/25, at 9:00 a.m., 2/4/25, at 9:15 a.m., and 2/5/25, at 11:12 a.m., Resident R15 was observed in room with left hand contracture (an abnormal thickening of tissues in the palm of the hand that over time can cause the fingers to curl in toward the palm) without the palm guard in place as ordered.</p> <p>Interview on 2/5/25, at 11:12 a.m. Licensed Practical Nurse (LPN) Employee E10 confirmed Resident R15's left hand was contracted and that the brace was not present over the past three days.</p> <p>Review of the admission record indicated R22 was admitted to the facility on [DATE].</p> <p>Review of Resident R22's MDS dated [DATE], indicated the diagnoses of Non-Alzheimer's Dementia (dementia caused by other diseases with symptoms forgetfulness, limited social skills, and impaired thinking abilities that interfere with daily functioning), Bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and high blood pressure.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R22's physician order dated 5/11/23, indicated resident is to use bilateral (both sides) wedges at lateral sides of knees and bilateral heel lift boots at all times when in bed except for during care.</p> <p>Review of Resident R22's physician order dated 10/4/23, indicated resident to use left knee extension splint (for gradual extension of nonfixed knee contracture) three to four hours daily during daylight shift, may remove for care.</p> <p>Review of Resident R22's care plan dated 2/3/25, indicated resident is to use bilateral wedges at lateral sides of knees and bilateral heel lift boots at all times when in bed except for during care, and resident to use left knee extension splint three to four hours daily during daylight shift, may remove for care.</p> <p>Observations on 2/3/25, at 9:00 a.m., 2/4/25, at 9:15 a.m., and 2/5/25, at 11:12 a.m., Resident R22 was observed in bed, without bilateral wedges at lateral sides of knees and bilateral heel lift boots, and without left knee extension splint. Equipment noted on the top of the wardrobe closet.</p> <p>Interview on 2/5/25, at 11:15 a.m. Nurse Aide (NA) Employee E11 indicated there is only one restorative staff for the entire facility with five separate floors, and restorative isn't here every day, and frequently gets pulled to care assignments. The floor aides do not apply the splints. I know he hasn't had them on for the last three days.</p> <p>Review of the admission record indicated R43 was admitted to the facility on [DATE].</p> <p>Review of Resident R43's MDS dated [DATE], indicated the diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness), and anemia.</p> <p>Review of Resident R43's care plan dated 1/23/25, indicated resident is dependent for all activities of daily living and care needs.</p> <p>Observations on 2/4/25, at 9:15 a.m., and 2/5/25, at 11:12 a.m., Resident R22 was observed in bed, with left hand visibly contracted.</p> <p>Interview on 2/5/25, at 11:20 a.m. LPN Employee E10 confirmed Resident R22 had a left-hand contracture and that he did not have a splint ordered as required to protect his palm.</p> <p>Review of the admission record indicated R45 was admitted to the facility on [DATE].</p> <p>Review of Resident R45's MDS dated [DATE], indicated the diagnoses of cerebral palsy (a congenital disorder of movement, muscle tone, or posture caused by abnormal brain development), high blood pressure, and quadriplegia (a symptom of paralysis that affects all of a person's limbs and body from the neck down).</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R45's current physician orders indicated resident to wear right elbow extension splint and left-hand splint at the same time for two to four hours during the daylight shift alternating with left elbow and right-hand splints for two to four hours during the daylight shift as tolerated by resident. Off during meals.</p> <p>Review of Resident R45's care plan dated 11/19/24, indicated resident to wear right elbow extension splint and left-hand splint at the same time for two to four hours during the daylight shift alternating with left elbow and right-hand splints for two to four hours during the daylight shift as tolerated by resident. Off during meals.</p> <p>Observations on 2/3/25, at 9:00 a.m., and 2/5/25, at 11:12 a.m., Resident R45 was observed in bed, without his right elbow extension splint and left-hand splint, or his left elbow and right-hand splints.</p> <p>Interview on 2/5/25, at 11:30 a.m. Nurse Aide (NA) Employee E11 confirmed Resident R45 has not been wearing his splints as ordered, and the floor aides do not apply the assistive devices.</p> <p>Review of the admission record indicated R50 was admitted to the facility on [DATE], and readmitted [DATE].</p> <p>Review of Resident R50's MDS dated [DATE], indicated the diagnoses of acquired absence of right leg below knee, contracture, and muscle weakness.</p> <p>Review of Resident R50's current physician orders dated 12/4/24, indicated resident to wear left knee extension splint when in bed for 3-4 hours during the daylight shift as tolerated by resident.</p> <p>Review of Resident R50's care plan dated 2/3/25, indicated resident to wear left knee extension splint when in bed 3-4 hours daily during the daylight shift as tolerated by the resident. The facility failed to timely implement a care plan for Resident R50's splint. A total of 61 days since the resident was ordered the left knee extension splint.</p> <p>During an observation and interview on 2/3/25, at 9:55 a.m., Resident R50 was observed in bed without his left knee extension splint. Resident R50 indicated the facility does nothing for his good leg.</p> <p>During an observation and interview on 2/3/25, at 12:49 p.m. Resident R50 was observed again without his left knee extension splint. He indicated he is supposed to have an arm brace too. Resident R50 stated he only had his knee brace on about one to two times since he's been in the facility. Resident R50 indicated no one has offered him his left knee extension splint and stated he is unsure where it even is.</p> <p>During an interview on 2/3/25, at 12:56 p.m. Licensed Practical Nurse, Employee E17 was asked if he seen Resident R50's left knee extension splint and he stated I don't know if I seen it the last few days, honestly I haven't looked. LPN, Employee E17 confirmed the facility failed to provide Resident R50's left knee extension splint as ordered.</p> <p>During an observation on 2/5/25, at 11:42 a.m. Resident R50 was observed lying in bed without his left knee extension splint intact. He indicated he is unsure if he has one.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/5/25, at 11:51 a.m. LPN, Employee E19 confirmed Resident R50's knee splint was not available and she was unsure where it was.</p> <p>Interview on 2/5/25, at 11:50 a.m. [NAME] President of Clinical Employee E9 indicated the restorative program is broken and confirmed the facility failed to provide treatment and services to prevent further decrease in range of motion for five of seven residents (Residents R15, R22, R43, R45, and R50).</p> <p>28 Pa. Code: 201.29(j) Resident rights.</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577</p> <p>Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to make certain that weight loss was identified and addressed in a timely manner and failed to update an individualized care plan to address the resident's specific nutritional concerns and preferences for one of seven (Resident R121) records reviewed.</p> <p>Findings include:</p> <p>Review of facility policy Nutritional Assessment, dated 1/15/24, indicated as part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition , shall be conducted for each resident. Individualized care plans shall address, to the extent possible:</p> <ol style="list-style-type: none"> a. The identified causes of impaired nutrition; b. The resident's personal preferences; c. Goals and benchmarks for improvement; d. Time frames and parameters for monitoring and reassessment. <p>The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions:</p> <p>- Section K0300: significant weight loss is defined as 5% weight loss or more in 30 days or 10% weight loss or more in 180 days</p> <p>GUIDANCE S483.25(g)</p> <p>Significant weight loss is defined as:</p> <p>5% or greater in one month</p> <p>7.5% or greater in three months</p> <p>10% or greater in six months</p> <p>Review of the clinical record revealed Resident R121 was originally admitted to the facility on [DATE], with readmitted [DATE].</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Corner View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6655 Frankstown Avenue Pittsburgh, PA 15206	
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R121's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/7/25, indicated diagnoses cerebral infarction (also known as an ischemic stroke, occurs when blood flow to the brain is disrupted due to issues with the arteries that supply it), rheumatoid arthritis (chronic inflammatory disorder that affects your joints and other body systems), and, protein-calorie malnutrition.</p> <p>Review of Resident R121's MDS dated [DATE], Section K - Swallowing/Nutritional Status, Question K0300 Weight Loss was coded 2 indicating a loss of 5% or more in the last month or loss of 10% or more in last 6 months and not on a physician-prescribed weight-loss regimen.</p> <p>Review of Resident R121's Vitals - Weights revealed the following documented weights:</p> <p>12/31/2024 - 193.8 lbs (pounds) = 17.5 % weight loss (41.2 lbs) within 1 month</p> <p>12/6/2024 - 235.0 lbs</p> <p>12/6/2024 - 230.0 lbs</p> <p>Review of clinical nutrition/dietary note dated 1/9/25, referenced to coordinate with MDS ARD (Assessment Reference Date) 1/7/25, failed to indicate Resident R121's weight history, and therefore failing to identify and assess resident's significant loss in weight.</p> <p>Review of Resident R121's nutritional care plan initiated 1/30/25, failed to identify significant weight loss as a nutritional problem, and failed to have updated goals and interventions to monitor, reassess, and address resident's specific nutritional concerns.</p> <p>During an interview on 2/7/25, at 10:30 a.m., Registered Dietitian (RD) Employee E21 stated that she did not document or address Resident R121's significant weight loss in her clinical notes or care plan, and confirmed that the facility failed to make certain that weight loss was identified and addressed in a timely manner and failed to update an individualized care plan to address the resident's specific nutritional concerns and preferences for one of seven (Resident R121) records reviewed.</p> <p>28 Pa. Code: 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code: 211.12(d)(1)(3)(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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577</p> <p>Based on facility policy, clinical record review and staff interview, it was determined the facility failed to provide appropriate care and services to residents receiving tube feedings for two of five residents reviewed (Residents R121, and R269).</p> <p>Findings Include:</p> <p>Review of facility policy Enteral Nutrition dated 1/15/24, indicated adequate nutrition support through enteral nutrition is provided to residents as ordered. The Nurse confirms that orders for enteral nutrition are complete. Complete orders include:</p> <ul style="list-style-type: none"> - The enteral nutrition product; - The specific enteral access device (nasogastric, gastric, jejunostomy tube, etc.); - Administration method (continuous, bolus, intermittent); - Volume and rate of administration; - The volume/rate goals - Instructions for flushing <p>Review of facility policy Nutritional Assessment, dated 1/15/24, indicated as part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. Individualized care plans shall address, to the extent possible:</p> <ol style="list-style-type: none"> a. The identified causes of impaired nutrition; b. The resident's personal preferences; c. Goals and benchmarks for improvement; d. Time frames and parameters for monitoring and reassessment. <p>Review of the clinical record revealed Resident R121 was originally admitted to the facility on [DATE], with readmitted [DATE].</p> <p>Review of Resident R121's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/7/25, indicated diagnoses cerebral infarction (also known as an ischemic stroke, occurs when blood flow to the brain is disrupted due to issues with the arteries that supply it), rheumatoid arthritis (chronic inflammatory disorder that affects your joints and other body systems), and, protein-calorie malnutrition. MDS Section K0520 indicated a feeding tube present.</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 physician order dated 12/31/24, indicated an enteral feed order every shift administer [NAME] Farms Standard 1.4 via GT (gastrostomy tube) at a rate of 65cc/hr (cubic centimeter per hour) to begin at 1400 (2:00 p.m.), and end at 0600 (6:00 a.m.). Physician order failed to indicate the total volume of [NAME] Farms 1.4 formula over the 16 hours period of administration, and failed to identify the mechanism for administration (pump or gravity).</p> <p>Review of Resident R121's current care plan initiated 1/2/25, with revision on 1/30/25, failed to include physician ordered care and services appropriate for receiving enteral nutritional support.</p> <p>Review of the clinical record revealed Resident R269 was admitted to the facility on [DATE].</p> <p>Review of Resident R269's clinical record indicated diagnoses on admission to include ischemia of the large intestines (a disorder that develops when blood flow to the colon is partially or completely blocked), high blood pressure, and protein-calorie malnutrition.</p> <p>Review of Resident R269's clinical progress note on 2/3/25, at 10:59 p.m., indicated resident alert and oriented times 3. PEG tube patent and intact. Tolerating enteral feed, meds, and flushes without difficulty.</p> <p>Review of physician order dated 1/31/25, indicated an enteral feed order every shift administer Isosource via PEG (Percutaneous endoscopic gastrostomy tube) at a rate of 55ml/hr (milliliters per hour) to begin at 1400 (2:00 p.m.), and end at 0600 (6:00 a.m.). Physician order failed to indicate the total volume of Isosource formula over the 16 hours period of administration, and failed to identify the mechanism for administration (pump or gravity).</p> <p>During an interview on 2/6/25, at 10:10 a.m., [NAME] President of Clinical Operations Employee E9 confirmed that the facility failed to provide appropriate care and services to residents receiving tube feedings for two of five residents reviewed (Residents R121, and R269).</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 211.10(c) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1) 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469</p> <p>Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care related to oxygen management for one of four residents (Resident R122).</p> <p>Findings include:</p> <p>A review of the facility policy Respiratory Therapy last reviewed on 2/3/25, indicates obtain equipment (i.e., oxygen tubing, reservoir, and distilled water) change the oxygen cannula and tubing every seven days or as needed.</p> <p>A review of Resident R122's clinical record indicates an admitted [DATE].</p> <p>A review of R122's Minimum Data Set (MDS-periodic assessment of care needs) dated 12/9/24, indicate the diagnosis of hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD- constriction of airways) and anxiety.</p> <p>During an observation on 2/3/25, at 10:19 Resident R122 was in bed, her oxygen was on via nasal canula (thin flexible tube used to deliver oxygen). The oxygen tubing failed to be labeled with a date.</p> <p>During an interview completed on 2/3/25, at 12:03 p.m. Licensed Practical Nurse (LPN) Employee E24 confirmed the oxygen tubing failed to be labeled with a date.</p> <p>A review of Resident R122's physician orders dated 4/8/24, indicate patient is to remain on 2-5 liters high flow oxygen, patient is O2 (oxygen) dependent every shift and failed to include the percentage of oxygen saturation to maintain comfort or the method of oxygen delivery.</p> <p>During an interview completed on 2/7/25, at 12:40 p.m. Registered Nurse (RN) Supervisor Employee E13 confirmed the order failed to include the percentage of oxygen saturation to maintain comfort or the method of oxygen delivery and confirmed that the facility failed to provide appropriate respiratory care related to oxygen management for one of four residents (Resident R122).</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event) for three of 11 residents reviewed (Resident R23, R45, and R85).</p> <p>Findings include:</p> <p>Review of the facility policy Trauma Informed Care dated 2/3/25, indicated the purpose to guide staff in appropriate and compassionate care specific to individuals who have experienced trauma, and post-traumatic stress disorder in the context of the healthcare setting. Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers that are person-centered.</p> <p>Review of the clinical record indicated Resident R23 was admitted to facility on 8/15/24, with the diagnosis of anxiety, cerebellar ataxia (affects balance gait, and eye movements) and PTSD.</p> <p>Review of Resident R23's care plan dated 1/19/24, indicated the resident has been exposed to a traumatic event related to PTSD diagnosis. The care plan did not include specific triggers.</p> <p>There was no documented evidence the facility identified Resident 23's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring.</p> <p>Review of the admission record indicated Resident R45 was admitted to the facility on [DATE].</p> <p>Review of Resident R45's MDS dated [DATE], indicated the diagnoses of cerebral palsy (a congenital disorder of movement, muscle tone, or posture caused by abnormal brain development), high blood pressure, and quadriplegia (a symptom of paralysis that affects all of a person 's limbs and body from the neck down), and PTSD.</p> <p>Review of Resident R45's care plan dated 2/5/25, indicated resident has psychosocial well-being problem related to relational trauma by maternal abuse. The care plan did not include specific triggers.</p> <p>There was no documented evidence the facility identified Resident 45's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring.</p> <p>Review of the clinical record indicated Resident R85 was admitted to facility on 12/3/24.</p> <p>Review of Resident R85's MDS dated [DATE], indicated the diagnosis of atrial fibrillation (rapid and irregular heart rhythm), bipolar disorder (mental health condition that causes extreme mood swings), and anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R85's care plan dated 5/5/24, indicated the resident has a psychosocial wellbeing problem actual PTSD related to reported history of physical abuse, vehicular accident.</p> <p>There was no documented evidence the facility identified Resident 85's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring.</p> <p>Interview with Social Services Director Employee E8, on 2/6/25, at 9:42 a.m. confirmed the facility failed to identify specific triggers, and failed to ensure that residents received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of PTSD for three of 11 residents reviewed (Resident R23, R45, and R85).</p> <p>28 Pa Code 201.24(e)(4) Admission Policy.</p> <p>28 Pa Code 211.12(a)(d)(3)(5) Nursing Services.</p> <p>28 Pa. Code 211.16(a) Social Services.</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>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>49469</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 for one of eleven residents (Resident R23).</p> <p>Findings include:</p> <p>Review of the facility policy Trauma Informed Care last reviewed 2/3/25, indicated this facility supports a culture of emotional well-being and physical safety for staff, residents and visitors. Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident ' s triggers. As part of the comprehensive assessment, identify history of trauma or interpersonal violence when possible. Identifying past trauma or adverse experiences may involve record review or the use of screening tools.</p> <p>Review of the Social Services job description indicated it is the responsibility of Social Services to ensure that the medically related emotional and social needs of residents are met/maintained on an individual basis. Develop social assessment and care plan, which identifies medically related social and emotional problems and needs with realistic goals and specific actions to be taken.</p> <p>Review of the clinical record indicated Resident R23 was admitted to facility on 8/15/24, with the diagnosis of bipolar disorder (causes extreme mood swings) post-traumatic stress disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event) and anxiety.</p> <p>Review of the nursing progress notes dated 2/5/25, at 12:18 p.m. physician updated about suicidal ideations which is not new for patient. Social services going to see patient and discuss concerns.</p> <p>Review of nursing progress note dated 2/5/25, at 4:07 p.m., indicated This writer spoke with social services regarding residents' concerns. Consulted with resident and made aware of how she is feeling and her newly increased anxiety. Placed call to physician informing him of current situation. New orders for Haloperidol 5mg PO (by mouth) q (every) 4 (hours) PRN (as needed) for anxiety. Resident informed and educated on medication purpose and uses. Residence expressed appreciation while tearful but able to verbalize when to seek nursing for guidance and medication as ordered. Will follow up with social services. No other issues at this time. Will continue to monitor.</p> <p>During an interview on 2/6/25, at 9:42 a.m. Social Services Director Employee E8, indicated if a resident is expressing suicidal ideation, a psychosocial assessment would be completed and confirmed the assessment was not completed for Resdient R23.</p> <p>Review of Resident R23's care plan on 2/6/25, failed to include interventions for suicidal ideation.</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 interview on 2/6/25, at 12:00 p.m. the Registered Nurse (RN) Supervisor Employee E13 stated I called the physician and received the new orders for Haldol, I had social service talk to her; confirmed the care plan did not have any intervention in place for Resident R23's suicidal ideations and confirmed the facility failed to ensure that a resident who displayed mental or psychosocial adjustment difficulties received appropriate treatment and services for one of eleven residents (Resident R23).</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by one of four residents reviewed (Resident 35).</p> <p>Findings include:</p> <p>Review of the facility Dementia-Clinical Protocol policy last reviewed 2/3/25, indicated for an individual with a confirmed dementia diagnosis, the interdisciplinary team will identify a resident-care centered care plan to maximize remaining function and quality of life.</p> <p>Review of Resident R35's clinical record indicated she was admitted to the facility on [DATE], with a diagnosis of dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life), anxiety, and depression.</p> <p>A review of Resident 35's Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated 12/22/24, indicated that the facility assessed Resident R635 as having a diagnosis of dementia.</p> <p>A review of Resident R35's clinical record from 3/9/22, through 2/5/25, failed to indicate that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss.</p> <p>Interview on 2/5/24, at 1:25 p.m. Licensed Practical Nurse, Employee E17 confirmed the facility had no further documentation that the facility developed and implemented individualized person-centered care plans to address Resident R35's dementia diagnosis.</p> <p>Interview on 2/5/25, at 1:32 the [NAME] President of Clinical Services, Employee E9 confirmed the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by one of four residents reviewed (Resident 35).</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to make certain that residents receiving psychotropic medications have adequate indication for use for two of five sampled residents (Resident R35 and R43).</p> <p>Findings include:</p> <p>Review of the facility policy Psychotropic Medication Use dated 2/3/25, indicated residents will not receive medications that are not clinically indicated.</p> <p>Review of Resident R35's clinical record indicated she was admitted to the facility on [DATE], with a diagnosis of dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life), anxiety, and depression.</p> <p>A review of Resident 35's Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated 12/22/24, indicated that diagnoses were current.</p> <p>Review of Resident R35's physician order dated 1/26/25, indicated to administer 1.5ml of 2mg/ml Haloperidol Lactate at bedtime for schizophrenia.</p> <p>Review of Resident R35's physician order dated 1/26/25, indicated to administer 1 ml of 2mg/ml Haloperidol Lactate one time a day for schizophrenia.</p> <p>Review of Resident R35's clinical record on 2/5/25, at 11:00 a.m. failed to reveal a diagnosis of schizophrenia.</p> <p>Interview on 2/5/25, at 1:32 the [NAME] President of Clinical Services, Employee E9 confirmed the facility failed to ensure Resident R35's medication regime was free from potentially unnecessary medications.</p> <p>Review of the admission record indicated R43 was admitted to the facility on [DATE].</p> <p>Review of Resident R43's MDS dated [DATE], indicated the diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness), and anemia.</p> <p>Review of Resident R43's physician order dated 10/25/24, indicated Risperdal (an anti-psychotic medication) give 0.5 mg (milligrams) two times a day for depression.</p> <p>Review of Resident R43's Medication Administration Record (MAR) dated February 2025, indicated resident was receiving the medication as prescribed.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 2/5/25, at 2:38 p.m. Registered Nurse (RN) Supervisor Employee E13 confirmed the facility failed to have an appropriate indication for use diagnosis in the physician order for the antipsychotic medication Risperdal.</p> <p>Interview on 2/6/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to make certain that residents receiving psychotropic medications have adequate indication for two of five sampled residents (Resident R35 and R43).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(a)(b)(3) Management.</p> <p>28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Corner View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6655 Frankstown Avenue Pittsburgh, PA 15206	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>49469</p> <p>Based on review of facility policy, observations and staff interview it was determined that the facility failed to properly store medical supplies and biologicals in one of five medication carts (5th floor front hall medication cart) and one of three medication rooms (6th floor medication room).</p> <p>Findings include:</p> <p>A review of the facility policy Medication Labeling and Storage last reviewed 2/3/25, indicates medications for external use, as well as hazardous drugs and biologicals, are clearly marked as such, and are stored separately from other medications.</p> <p>A review of the facility policy Administering Medications last reviewed 2/3/25, indicated the expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi dose container, the date opened shall be recorded on the container.</p> <p>During an observation on 2/3/25, at 12:12 p.m. the 5th floor front hall medication cart contained the following:</p> <ul style="list-style-type: none"> . A bottle of Tums antacid tablets not labeled with date opened. . A small white bottle of shaving cream. . A can of sweet vanilla rainbow room spray. <p>During an interview completed on 2/3/25 at 12:17 p.m. Licensed Practical Nurse (LPN) Employee E6 confirmed the above observations.</p> <p>During an observation of the 6th floor medication storage room the following was discovered stored under the sink:</p> <ul style="list-style-type: none"> . 7 packages of briefs. . One bottle of drug disposal liquid. <p>During an interview on 2/4/25, at 10:48 a.m. Registered Nurse (RN) Employee E1 confirmed the above observation and that the facility failed to properly store medical supplies and biologicals in one of five medication carts (5th floor front hall medication cart) and one of three medication rooms (6th floor medication room).</p> <p>28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services.</p> <p>28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services.</p> <p>(continued on next page)</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 211.10(c) Resident care policies.

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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>45577</p> <p>Based on a review of policy, observation and staff interview, it was determined that the facility failed to properly maintain kitchen equipment in a sanitary condition creating the potential for cross contamination in the main kitchen of the facility.</p> <p>Findings include:</p> <p>Review of facility policy Food Safety Requirements: Sanitation of the Kitchen dated 2/3/25, indicated that Food Service Staff maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule.</p> <p>During an observation of the main designated kitchen on 2/3/25, initiated at 9:30 a.m., with Dietary Director Employee E25, the following was observed:</p> <ul style="list-style-type: none"> - Walk-in cooler #3, at 9:45 a.m.; -- the cold air condenser fan covers had a build-up of dust, grime, and dark colored debris. -- the floor had a build-up of grime and dried food debris below stored cases of milk. - Walk-in cooler #4, at 9:50 a.m.; -- the cold air condenser fan covers had a build-up of dust, grime, and dark colored debris; areas around the cooler fans immediately adjacent to and on ceiling forward of the fans had a build-up of dust, grime, and dark colored debris. <p>Above observations were confirmed by Dietary Director Employee E25 at time viewed with surveyor.</p> <p>During an interview on 2/3/25, at 9:52 a.m., Dietary Director Employee E25 confirmed that the facility failed to properly maintain kitchen equipment in a sanitary condition creating the potential for cross contamination in the main kitchen of the facility.</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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</p> <p>Based on review of facility policy, resident clinical records, observation, and staff interviews, it was determined that the facility failed to report, implement infection monitoring and management for COVID-19, and test residents timely for respiratory illnesses for two of two residents (Resident R80 and R369) and failed to prevent cross contamination during a medication pass for one of two residents (Resident R37).</p> <p>Finding include:</p> <p>Review of the facility Outbreak of Communicable Diseases reviewed 1/15/24, indicated outbreaks of communicable diseases within the facility are promptly identified and managed. An outbreak is defined as one case of an infection that is highly communicable or has serious implications. The administrator is responsible for communicating data about reportable diseases to the health department. The infection preventionist and director of nursing are responsible for managing surveillance data, monitoring ill residents and staff.</p> <p>Review of the Bureau of Epidemiology Respiratory Virus Outbreak Toolkit last updated 11/14/24, indicated long term care facilities need to procure their own testing supplies and the lab support needed to detect respiratory viruses like COVID-19, Influenza, and RSV in both residents and Health Care Personnel. If the respiratory virus is not one of the three for which there are point-of-care tests available, a lab needs to be available to perform an expanded respiratory panel. One laboratory-confirmed COVID-19 case indicates an outbreak. All respiratory outbreaks are reportable and must be reported to Department of Health within 24 hours of identification of the outbreak. When respiratory illness is first identified in residents or staff, the facility should implement daily symptoms monitoring and testing. A case line listing is designed to collect information about ill cases for residents and staff during an outbreak and can track the spread of the virus and monitor case counts until the outbreak has finished. An outbreak is considered over: when 14 days have passed since the last resident tested positive or became symptomatic (if no positive test). Any new infections in a resident for the applicable virus would restart the 14-day countdown.</p> <p>Review of the facility policy Administering Medications last reviewed 2/3/25, indicates staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic techniques, gloves, isolation precaution, etc.) for the administration of medications, as applicable.</p> <p>Review of the clinical record indicated Resident R369 was admitted to the facility on [DATE].</p> <p>Review of Resident R369's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/17/24, indicated diagnoses of opioid dependence, respiratory conditions due to smoke inhalation, and hip fracture.</p> <p>Review of Resident R369's progress note dated 12/19/25, indicated the resident complained of shortness of breath while sitting and walking. Resident R369 was not tested for respiratory illnesses.</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>Review of Resident R369's progress note dated 12/20/24, at 9:14 a.m. indicated the resident had increased anxiety and a moist productive cough. Resident had left lower scattered rhonchi. It was indicated the resident was self-expectorating white phlegm. Resident R369 was not tested for respiratory illnesses.</p> <p>Review of Resident R369's progress note dated 12/23/24, indicated the resident was waiting to go to an appointment in the lobby and complained of shortness of breath and his heart racing. The resident was sent to hospital for further evaluation.</p> <p>Review of Resident R369's progress note dated 12/24/24, entered by Infection Preventionist, Employee E20 indicated the resident tested positive for COVID. Will retest in 5 days per CDC recommendations.</p> <p>Review of documentation provided to the local state field office from 12/23/24, to 2/4/25, failed to include Resident R369's positive COVID diagnosis.</p> <p>Review of the clinical record indicated Resident R80 was admitted to the facility on [DATE].</p> <p>Review of Resident R80's MDS dated [DATE], indicated diagnoses of anxiety, depression, and muscle weakness.</p> <p>Review of Resident R80's progress note dated 1/1/25, indicated the resident has a cough and congestion. It was indicated the resident had audible wheezing noted on both inspiration and expiration. Resident R80 was not tested for respiratory illnesses during the facility's COVID outbreak.</p> <p>Review of Resident R80's progress note dated 1/3/25, indicated Registered Nurse, Employee E19 was called to assess the resident. It was indicated the resident was short of breathe and rhonchi (abnormal loud, continuous, low-pitched, snoring, or gurgling lung sound) was noted in the upper lungs. The resident's oxygen saturation (refer to the amount of oxygen circulating in the blood) was 84% on room air and 3 liters (L) of oxygen was applied via nasal cannula and the residents oxygen saturation improved to 90%. The resident's doctor and family was notified and the resident was transferred to the hospital. The resident was admitted with cough.</p> <p>During an interview on 2/5/25,at 10:21 a.m. Infection Preventionist, Employee E20 stated the facility in not currently in outbreak for COVID. The last outbreak was when Resident R369 tested positive for COVID was on 12/24/24. IP, Employee E20 indicated the facility completed a unit-based approach for outbreak testing. IP, Employee E20 stated she tested residents the day she received notification Resident R369 tested positive and on Day 5. IP, Employee failed to test residents on Day 3, as required. IP, Employee E20 stated the facility monitored residents after Day 5 and tested residents if they developed symptoms. IP, Employee E20 confirmed the facility failed to develop a line listing report for the facility's COVID outbreak that began on 12/24/24.</p> <p>During an interview on 2/6/25, at 9:16 a.m. the [NAME] President of Clinical Services, Employee E9 confirmed the facility failed to report, implement infection monitoring and management for COVID-19, and test residents timely for respiratory illnesses for two of two residents (Resident R80 and R369).</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 a medication pass observation completed on 2/4/25, at 9:00 a.m. Licensed Practical Nurse (LPN) Employee E23 administered Resident R152's medications, exited the room, removed gloves, donned a new pair of gloves, and began to prepare Resident R37's medications without completing hand hygiene.</p> <p>During an interview completed on 2/4/25, at 9:12 a.m. LPN Employee E23 confirmed administration of Resident R152's medication, exiting the room, removing gloves and donning a new pair of gloves without completing hand hygiene prior to beginning the preparation of R37's medications and that the facility failed to prevent cross contamination during a medication pass for one of two residents (Resident R37).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p> <p>28 Pa. Code: 211.12(d)(3) Nursing services.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>46337</p> <p>Based on review of the facility's infection control policies and procedures and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program for four of ten months (April 2024, May 2024, June 2024, July 2024).</p> <p>Findings include:</p> <p>Review of facility policy Infection Control Program reviewed 1/15/24, indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of the facility's Antibiotic Stewardship Program is to monitor the use of antibiotics in the residents.</p> <p>Review of facility policy Surveillance for Infections, last reviewed 1/15/24, indicated The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data.</p> <p>Review of the facility's Infection Control surveillance for April 2024 - January 2025, failed to include documentation to indicate that antibiotic monitoring was completed for four of ten months (April through July 2024).</p> <p>During an interview on 2/5/24, at 2:45 p.m., the [NAME] President of Clinical Services confirmed that the facility failed to implement an antibiotic stewardship program that included a system of surveillance to monitor antibiotic use and lab correlation for infections for four of ten months and was unable to produce the tracking records for April 2024, May 2024, June 2024, and July 2024.</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: 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>49469</p> <p>Based on observation and staff interview, it was determined that the facility failed to maintain an effective call system for 12 of 20 resident restrooms on one of five floors (6th floor).</p> <p>Findings include:</p> <p>Review of facility policy Call System, Resident last reviewed 2/3/25, indicates residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station</p> <p>During a group interview on 2/4/25, at 10:15 a.m. Residents indicated that the call bell in the bathroom did not work and it didn't let staff know that they needed help.</p> <p>During an observation on 2/5/25, 10:30 am thru 11:08 a.m. of the sixth-floor resident restrooms the following rooms were observed to have call light cords that when pulled were unable to be alarmed:</p> <ul style="list-style-type: none"> . 6010 . 6011 . 6012 . 6013 . 6016 . 6017 . 6018 . 6019 . 6020 . 6021 . 6023 . 6040 <p>During an interview completed on 2/4/25, at 11:10 a.m. Nurse Aid (NA) Employee E26 confirmed the above observations.</p> <p>(continued on next page)</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview completed on 2/4/25, at 11:34 a.m. the Nursing Home Administrator confirmed that the facility failed to maintain an effective call system for 12 of 20 resident restrooms on one of five floors (6th floor).</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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility documentation and interviews with staff, it was determined that the facility failed to develop, implement, and maintain an effective training program that was sufficient to meet the requirement for facility-provided annual nurse aide education for three of five employee files (Nurse Aide (NA) Employees E3, E14, and E15).</p> <p>Findings include:</p> <p>Review of NA Employee E3's personnel record indicated she was hired to the facility on [DATE].</p> <p>Review of NA Employee E14's personnel record indicated she was hired to the facility on [DATE].</p> <p>Review of NA Employee E15's personnel record indicated she was hired to the facility on [DATE].</p> <p>Review of annual in-service documentation and personnel records did not include an annual in-service training on Quality Assurance and Performance Improvement (QAPI), Communication, and Compliance and Ethics training.</p> <p>Interview on 2/5/25, at 1:54 p.m. the Director of Nursing confirmed that facility failed to develop, implement, and maintain an effective training program that was sufficient to meet the requirement for facility-provided annual nurse aide education for three of five employee files (Nurse Aide (NA) Employees E3, E14, and E15).</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 201.20 (a) (c) Staff development</p> <p>28 Pa. Code 201.29 (d) Resident rights</p> <p>28 Pa. Code 201.19(7) Personnel policies and procedures.</p>		