

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Laureldale Skilled Nursing and Rehabilitation Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 Elizabeth Avenue Laureldale, PA 19605	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>14599</p> <p>Based on clinical record review, facility documentation reivew, and staff interview, it was determined that the facility failed to ensure that the responsible party was notified of a change in condition and a fall for one of three sampled residents. (Resident 1)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 1 had diagnoses that included muscle wasting, hypertension, history of transient ischemic attacks, atherosclerotic cardiovascular disease, and chronic respiratory failure. On August 6, 2024, at 3:15 p.m., a nurse noted that the resident fell after using the toilet. According to the facility investigation into the fall, the resident's responsible party was not notified of the fall until the following day at 3:30 p.m. In an interview on August 16, 2024, the Director of Nursing stated that staff was to notify the responsible immediately after a fall.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14599</p> <p>Based on clinical record review, facility documentation review, and staff interview, it was determined that the facility failed to keep one of three sampled residents free from neglect, which resulted in actual harm of a head injury. (Resident 1)</p> <p>Findings include.</p> <p>Clinical record review revealed that Resident 1 had diagnoses that included muscle wasting, hypertension (high blood pressure), history of transient ischemic attacks (temporary interruptions of blood supply to the brain), atherosclerotic cardiovascular disease (a condition of increased plaque in the arteries of the heart, potentially causing heart attacks), and chronic respiratory failure. The Minimum Data Set (MDS) assessment (a periodic evaluation of resident care needs) dated [DATE], indicated that the resident had a history of falls and required maximum assistance to use the toilet. The care plan identified that Resident 1 was at risk for falls and required assistance with activities of daily living (basic self-care tasks such as personal hygiene and using the toilet), and that staff was to use two people to assist the resident to walk and transfer from one surface to another.</p> <p>On [DATE], a nurse noted that the resident fell in the bathroom while a nurse aide was attempting to assist him onto the toilet. On [DATE], the resident was evaluated by a physical therapist. The therapist noted that the resident was having more difficulty with transferring from one surface to another (such as getting on and off the toilet) and that staff was to use two or more helpers. On [DATE], a nurse noted that the resident was having difficulty standing and needed additional help.</p> <p>On [DATE], a nurse noted that the resident fell at 10:28 a.m., while being assisted with toileting. According to the facility incident investigation, only one nurse aide was assisting the resident at the time. While transferring off the toilet, the resident's knees buckled and he fell, striking his head on the floor. The nurse practitioner noted that the resident suffered a hematoma (a collection of blood under the skin) and bleeding on his head. At the time, the nurse practitioner also noted that the resident was dazed and was having difficulty breathing. The resident was monitored by staff but refused to be transported to a hospital for further evaluation. At 11:30 a.m., the resident stopped breathing and staff was unable to revive him. According to the facility investigation into the fall, the nurse aide who provided the assistance was aware of the need for two staff members and assisted the resident off the toilet alone despite the need for two people.</p> <p>In an interview on [DATE], at 1:00 p.m., the Director of Nursing stated that at the time of the fall, two staff should have assisted the resident instead of one.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14599</p> <p>Based on clinical record review, facility documentation review, and staff interview, it was determined that the facility failed to provide adequate supervision and interventions to prevent accidents related to falls for one of three sampled residents which resulted in actual harm of a head injury. (Resident 1)</p> <p>Findings include.</p> <p>Clinical record review revealed that Resident 1 had diagnoses that included muscle wasting, hypertension (high blood pressure), history of transient ischemic attacks (temporary interruptions of blood supply to the brain), atherosclerotic cardiovascular disease (a condition of increased plaque in the arteries of the heart, potentially causing heart attacks), and chronic respiratory failure. The Minimum Data Set (MDS) assessment (a periodic evaluation of resident care needs) dated [DATE], indicated that the resident had a history of falls and required maximum assistance to use the toilet. The care plan identified that Resident 1 was at risk for falls and required assistance with activities of daily living (basic self-care tasks such as personal hygiene and using the toilet), and that staff was to use two people to assist the resident to walk and transfer from one surface to another.</p> <p>On [DATE], a nurse noted that the resident fell in the bathroom while a nurse aide was attempting to assist him onto the toilet. On [DATE], the resident was evaluated by a physical therapist. The therapist noted that the resident was having more difficulty with transferring from one surface to another (such as getting on and off the toilet) and that staff was to use two or more helpers. On [DATE], a nurse noted that the resident was having difficulty standing and needed additional help.</p> <p>On [DATE], a nurse noted that the resident fell at 10:28 a.m., while being assisted with toileting. According to the facility incident investigation, only one nurse aide was assisting the resident at the time. While transferring off the toilet, the resident's knees buckled and he fell, striking his head on the floor. The nurse practitioner noted that the resident suffered a hematoma (a collection of blood under the skin) and bleeding on his head. At the time, the nurse practitioner also noted that the resident was dazed and was having difficulty breathing. The resident was monitored by staff but refused to be transported to a hospital for further evaluation. At 11:30 a.m., the resident stopped breathing and staff was unable to revive him.</p> <p>In an interview on [DATE], at 1:00 p.m., the Director of Nursing stated that at the time of the fall, two staff should have assisted the resident instead of one.</p> <p>CFR: 483.25(d) Accidents</p> <p>Previously cited [DATE]</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(5) Nursing Services.		