

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Slate Belt Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Slate Belt Blvd, Rd 3 Bangor, PA 18013	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45840</p> <p>Based on observation and resident interview, it was determined that the facility failed to ensure that meals were served in a manner that maintained each resident's dignity for one of 22 sampled residents. (Resident 79)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 79 had diagnoses that included rheumatoid arthritis, dysphagia (difficulty swallowing), and protein-calorie malnutrition. The Minimum Data Set assessment dated [DATE], indicated that the resident was alert and oriented and had limitations on both sides of his upper extremities. The care plan identified that the resident had a self-care deficit related to muscle weakness and contractures. There was an intervention for staff to provide total assistance with eating.</p> <p>Observation of the lunch meal on the 2nd floor nursing unit on February 26, 2025, at 12:08 p.m., revealed Resident 39 and Resident 79 seated in their room awaiting lunch. At 12:12 p.m., Resident 39 was served and eating their meal. Resident 79 was observed without a meal and making comments, including, When do I get my food? At 12:35 p.m., Resident 79 used the call bell, State Trained Nursing Assistant (STNA) 1 entered the room, and Resident 79 stated, I didn't get my food. Resident 79 was not assisted with his lunch tray until 12:38 p.m.</p> <p>In an interview on February 27, 2025, the Director of Nursing stated that Residents 39 and 79 should have had their meals provided at the same time.</p> <p>28 Pa. Code 201.29(a) Resident rights.</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 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>45840</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to implement physician's orders for one of 22 sampled residents. (Resident 85)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 85 had diagnoses that included congestive heart failure, pulmonary hypertension, and chronic kidney disease. A physician's order dated January 30, 2025, directed staff to weigh the resident daily. A review of the Medication Administration Record (MAR) for February 2025, revealed that there was no evidence that staff weighed Resident 85 as ordered on February 9, 11, 15, 16, and 25, 2025.</p> <p>In an interview on February 27, 2025, at 10:58 a.m., the Director of Nursing confirmed that there was no documented evidence that the resident was weighed as ordered.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		