| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395530 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Presbyterian Homes-Presby | 220 Newry Street<br>Hollidaysburg, PA 16648 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>31760<br><br>Based on review of policies, investigative reports, and residents' clinical records, as well as staff and family interviews, it was determined that the facility failed to ensure that residents were free from neglect caused by a failure to follow the facility's policy for obtaining temperatures of hot liquids for one of two residents reviewed (Resident 1), resulting in the resident spilling her coffee and causing a burn. This deficiency was cited as past noncompliance.<br><br>Findings include:<br><br>The facility's policy regarding resident abuse, dated February 8, 2024, revealed that each resident is provided a safe environment where they are not subjected to mental, physical, verbal, and sexual abuse. Residents shall also be protected from mistreatment, neglect, exploitation, and misappropriation of property. Neglect is defined as the failure of the facility, its employees, or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.<br><br>The facility's policy regarding reheating of hot food/beverages, dated February 8, 2024, revealed that when serving hot beverages, the maximum temperature should not be greater than 140 degrees Fahrenheit (F). An accurate temperature of all menu items, including hot beverages, were to be taken and recorded on the food temperature log.<br><br>The facility's policy regarding food temperature logs, dated February 8, 2024, revealed that food temperatures of cold and hot items will be recorded on all menu items for meal service. All employees are responsible for notifying their supervisor of any food items that are not in the regulated safe acceptable service ranges (below 41 degrees F or above 135 degrees F).<br><br>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated June 2, 2024, revealed that the resident was understood, could understand others, had a diagnosis which included Parkinson's disease, and was on a mechanically altered diet (foods that are easy to chew and swallow because they are blended, chopped, grounded, or mashed). A care plan for the resident, dated June 5, 2024, revealed that the resident had a potential risk for altered nutritional status and/or weight loss related to dementia and prefers to eat in the dining room. At times the resident requires assistance with feeding, and staff were to provide assistance as needed.<br><br>(continued on next page) |

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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395530 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/22/2024 |
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| NAME OF PROVIDER OR SUPPLIER: Presbyterian Homes-Presby | | STREET ADDRESS, CITY, STATE, ZIP CODE: 220 Newry Street Hollidaysburg, PA 16648 | |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Physician's orders for Resident 1, dated June 11, 2024, included an order for the resident to receive a mechanical soft regular diet with thin liquids.<br><br>A speech therapy note for Resident 1, dated June 21, 2024, revealed that the writer spoke with nurse aides/nursing staff to inform them that the resident had no changes in her speech/swallow/cognition, and that the resident was at her baseline.<br><br>A nursing note for Resident 1, dated June 30, 2024, at 6:30 p.m. revealed that the writer was called to the resident's room for a report of the resident spilling coffee and obtaining a burn. The resident was noted to have an area to her right upper thigh 30 centimeter (cm) by 10 cm, and two areas on her lower right abdomen measuring 10 cm by 6 cm and 6 cm by 1 cm. The areas were red with no blisters noted at the time of assessment. Orders were received from the physician for Silvadene (used to treat and prevent wound infections in people with severe burns) to the areas every shift and cool compress to the areas times 20 minutes as needed. Emergency contact was updated on the events. A nursing note at 7:06 p.m. revealed that a registered nurse assessment was done due to the resident spilling her coffee and obtaining a burn. The resident continued to have a reddened area noted to her upper right thigh by her groin area. One blister was noted on her thigh at the time of assessment.<br><br>An Interdisciplinary Team note for Resident 1, dated July 1, 2024, at 9:33 a.m. revealed that on June 30, 2024, at 4:15 p.m. the resident was observed by a visitor spilling coffee into her lap. The resident was noted to have an area to her right upper thigh 30 cm by 10 cm and two areas on lower right abdomen measuring 10 cm by 6 cm and 6 cm by 1 cm. The areas were noted to be red without blisters at the time of initial assessment. Upon review by the wound nurse that morning, there were seven blistered areas noted. The physician and family were aware.<br><br>A nursing note for Resident 1, dated July 2, 2024, at 12:40 p.m. revealed that the wound nurse saw the resident that morning for a follow up on her burns to her abdomen and right anterior (the front surface of) thigh. On assessment that morning, the redness to the abdomen had resolved, the abdominal open area just below the umbilicus is unchanged in size, and there was a scant amount of clear/yellow serous (a clear fluid that leaks out of wounds) drainage. On assessment, the burn to her right anterior thigh had changed from yesterday's assessment. Of the seven blisters reported in the assessment yesterday, three had ruptured while four remain intact. The redness at the site of the right anterior thigh has almost completely resolved, with some diffuse areas of pink coloration still remaining.<br><br>A skin condition note for Resident 1, dated July 4, 2024, revealed that the resident had a third degree burn (a serious wound that damages all three layers of skin) to her right anterior thigh, secondary to a hot beverage spill, that measures 7.5 cm by 23.0 cm by 0.1 cm. The current treatment was to cleanse the burned area to her right anterior thigh with wound cleanser, pat dry, apply Silvadene to the wound base, then apply Xeroform (a fine mesh gauze occlusive dressing impregnated with petrolatum and 3 percent Xeroform) cut-to-fit the wound base, cover with ABD pad (a gauze dressing that absorbs fluid from large or heavily draining wounds), and secure with netted retention gauze or rolled gauze and tape once daily and as needed.<br><br>A nursing note for Resident 1, dated July 4, 2024, revealed that the resident's daughter was provided an update on the degree of the burns and current appearance as well as the treatment changes.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395530 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/22/2024 |
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| NAME OF PROVIDER OR SUPPLIER Presbyterian Homes-Presby | | STREET ADDRESS, CITY, STATE, ZIP CODE 220 Newry Street Hollidaysburg, PA 16648 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A statement completed by a resident's visiting family member, dated June 30, 2024, revealed that Dietary Server 1 came over and sat the coffee down with no lid. Resident 1 picked up the cup, took a drink, and stated, that's hot. She set the cup down and then spilled it soon after.<br><br>A statement completed by Dietary Server 1, dated June 30, 2024, revealed that he got Resident 1 a cup of coffee and set it down in front of her.<br><br>A statement completed by Registered Nurse 2, dated June 30, 2024, revealed that she was called to Resident 1's room for reports of a burn. The resident was in bed with three burn areas, two on her stomach measuring 6 cm by 1 cm and 10 cm by 6 cm, and the third area was on the resident's right upper thigh and down between her legs and measured 30 cm by 10 cm. Registered Nurse 2 went to the kitchen, asked for the coffee pot that the resident was served from, and the temperature of the coffee was 164.1 degrees F. While temping the coffee in the pot, Dietary Server 1 said, The pot has been there for hours. Registered Nurse 2 asked him if the resident had a lid and he said no.<br><br>A statement completed by Dietary Aide 3, dated July 1, 2024, revealed that on June 30, 2024, she worked breakfast and lunch. She made coffee during lunch about 12:30 p.m., which she did not temp, and Resident 1 got coffee at dinner and got burnt. It was from the same pot that she had made for lunch. She knew that she should have temped it and not to serve it unless it is 140 degrees F. She did not temp it because she was busy then forgot.<br><br>A statement completed by the Dining Services Director, dated June 30, 2024, revealed that on June 30, 2024, at approximately 5:30 p.m. he spoke with Dietary Server 1 via phone. He was informed that Dietary Server 1 had used a pot of coffee previously brewed for lunch and did not log the temperature of the coffee being served. He was aware of the requirement to log the temperatures of hot beverages and acknowledged that coffee needs to be under 140 degrees F. He confirmed that he did not brew the coffee that caused the burn, and it was from lunch.<br><br>A statement completed by the Assistant Dining Services Director, dated July 1, 2024, revealed that she called Dietary Server 1 and asked why he did not take the temperature of the coffee and he said that he forgot. The coffee pot out front of the counter was empty, so he pulled the full pot that was there already from the back of the counter, then placed the empty one to be brewed.<br><br>A statement completed by the Dining Services Director, dated July 3, 2024, revealed that he spoke with Dietary Server 1 on the phone on July 3, 2024, at 8:30 a.m. He had asked him if he had heard Resident 1 state that the coffee he served her was hot. He said that he did not hear the resident or anyone else make that statement.<br><br>An investigation summary revealed that on June 30, 2024, at 4:15 p.m. Resident 1 was observed by a visitor to have spilled coffee on her lap. The visitor notified staff, who called the registered nurse to assess the resident. The resident was noted to have three reddened areas to her right upper thigh (30 cm by 10 cm), her right lower quadrant (10 cm by 6 cm), and a separate area next to her right lower quadrant (6 cm by 1 cm). The provider was notified and ordered Silvadene Cream to the area and pain control with Tylenol (an over-the-counter pain medication) as needed. Upon reassessment at 7:00 p.m. the resident was noted to have three fluid-filled blisters to the right thigh, each measuring 2 cm by 2 cm. The registered nurse supervisor temped the coffee from the carafe that Resident 1 was served from, and it was temped at 165 degrees F. An investigation was initiated as the maximum temp for hot beverages per facility policy is 140 degrees F.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Presbyterian Homes-Presby | | STREET ADDRESS, CITY, STATE, ZIP CODE 220 Newry Street Hollidaysburg, PA 16648 | |

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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The investigation revealed that Dietary Server 1 served Resident 1 coffee that was above the maximum temperature of 140 degrees F per policy. This occurred at the start of the evening meal on Sunday, June 30, 2024. The resident received three burns after spilling the coffee on herself. A statement from Dietary Server 1 revealed that he should have temped the coffee prior to service. When asked why he did not temp the coffee he said, I forgot. Dietary Server 1 stated that the coffee in question was brewed at lunch. Dietary Server 1 was placed on administrative leave on June 30, 2024. Dietary Server 1 was last educated on the hot beverage policy on May 23, 2024. Dietary Aide 3 worked breakfast and lunch on June 30, 2024. It was determined that she had brewed the pot of coffee in question (at lunch time) that was later served to the resident several hours later. Dietary Aide 3 was asked if she brewed and temped the coffee at lunch time, to which she responded that she did brew the coffee, got busy and then forgot to temp it. Dietary Aide 3 was placed on administrative leave on July 1, 2024. Dietary Aide 3 was last educated on the hot beverage policy on May 24, 2024. Resident 1 was served coffee that was over the maximum temperature of 140 degrees F. The resident spilled the coffee on her lap and sustained three burns to her abdomen and right thigh. Dining staff did not follow the procedure for temping coffee prior to the meal service. Neglect was substantiated for Dietary Aide 3 and she was terminated on July 5, 2024.<br><br>Interview with the Nursing Home Administrator and the Assistant Director of Nursing on July 22, 2024, at 2:40 p.m. confirmed that the facility's investigation substantiated neglect because Dietary Aide 3 did not follow the facility's policy for temping hot beverages prior to the meal service.<br><br>Following the incident/investigation on June 30, 2024, the facility's corrective actions included:<br><br>Dietary Server 1 and Dietary Aide 3 were both placed on administrative leave. Dietary Aide 3 was terminated from employment at the facility July 5, 2024.<br><br>The coffee and hot water were removed from the units and discarded on June 30, 2024.<br><br>New pots of coffee were brewed, and the temperatures were verified to be under 140 degrees F before serving.<br><br>The next morning two staff brewed and temped the coffee made for the breakfast meal on July 1, 2024, and confirmed that the coffee was at 140 degrees F before service.<br><br>Coffee makers will be removed from the units and the coffee, as well as any hot beverages, will be made in the main kitchen and will be temped by two staff, verifying that the temperature is 140 degrees F or less.<br><br>Residents will be served hot beverages with coffee lids.<br><br>Dietary staff were re-educated on the facility's hot beverage policy, temperature logs, and educated on the new process for serving hot beverages, which was completed on July 1, 2024.<br><br>The nursing staff was educated on the new procedure that coffee is only brewed in the main kitchen and that the temperature is verified by two individuals.<br><br>Audits to identify any issues with the temperatures of hot beverages were started.<br><br>(continued on next page) |

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| Presbyterian Homes-Presby | 220 Newry Street Hollidaysburg, PA 16648 |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The results of these audits will be brought to the Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary.<br><br>Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F600 on July 1, 2024.<br><br>28 Pa. Code 201.14(a) Responsibility of Licensee.<br><br>28 Pa. Code 201.18(b)(1)(e)(1) Management.<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing Services. |

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

31760

Based on review of policies, clinical records, and facility investigation reports, as well as staff interviews, it was determined that the facility failed to provide an environment that was free of accident hazards by serving hot coffee in a cup without a lid to one of two residents (Resident 1) without first obtaining a temperature to ensure that it was not greater than 140 degrees Fahrenheit, resulting in third degree burns when it was spilled on the resident. This deficiency was cited as past non-compliance.

Findings include:

The facility's policy regarding reheating of hot food/beverages, dated February 8, 2024, revealed that when serving hot beverages the maximum temperature should not be greater than 140 degrees Fahrenheit (F). An accurate temperature of all menu items, including hot beverages, are to be taken and recorded on the food temperature log.

The facility's policy regarding food temperature logs, dated February 8, 2024, revealed that food temperatures of cold and hot items will be recorded on all menu items for meal service. All employees are responsible for notifying their supervisor of any food items that are not in the regulated safe acceptable service ranges (below 41 degrees F or above 135 degrees F).

A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated June 2, 2024, revealed that the resident was understood, could understand others, had a diagnosis which included Parkinson's disease, and was on a mechanically altered diet (foods that are easy to chew and swallow because they are blended, chopped, grounded, or mashed). A care plan for the resident, dated June 5, 2024, revealed that the resident had a potential risk for altered nutritional status and/or weight loss related to dementia and prefers to eat in the dining room. At times the resident requires assistance with feeding, and staff were to provide assistance as needed.

Physician's orders for Resident 1, dated June 11, 2024, included an order for the resident to receive a mechanical soft regular diet with thin liquids.

A speech therapy note for Resident 1, dated June 21, 2024, revealed that the writer spoke with nurse aides/nursing staff to inform them that the resident had no changes in her speech/swallow/cognition, and that the resident was at her baseline.

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|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A nursing note for Resident 1, dated June 30, 2024, at 6:30 p.m. revealed that the writer was called to the resident's room for a report of the resident spilling coffee and obtaining a burn. The resident was noted to have an area to her right upper thigh 30 centimeter (cm) by 10 cm, and two areas on her lower right abdomen measuring 10 cm by 6 cm and 6 cm by 1 cm. The areas were red with no blisters noted at the time of assessment. Orders were received from the physician for Silvadene (used to treat and prevent wound infections in people with severe burns) to the areas every shift and cool compress to the areas times 20 minutes as needed. Emergency contact was updated on the events. A nursing note at 7:06 p.m. revealed that a registered nurse assessment was done due to the resident spilling her coffee and obtaining a burn. The resident continued to have a reddened area noted to her upper right thigh by her groin area. One blister was noted on her thigh at the time of assessment.<br><br>An Interdisciplinary Team note for Resident 1, dated July 1, 2024, at 9:33 a.m. revealed that on June 30, 2024, at 4:15 p.m. the resident was observed by a visitor spilling coffee into her lap. The resident was noted to have an area to her right upper thigh 30 cm by 10 cm and two areas on lower right abdomen measuring 10 cm by 6 cm and 6 cm by 1 cm. The areas were noted to be red without blisters at the time of initial assessment. Upon review by the wound nurse that morning, there were seven blistered areas noted. The physician and family were aware.<br><br>A skin condition note for Resident 1, dated July 4, 2024, revealed that the resident had a third degree burn (a serious wound that damages all three layers of skin) to her right anterior thigh secondary to a hot beverage spill that measured 7.5 cm by 23.0 cm by 0.1 cm. The current treatment was to cleanse the burned area to her right anterior thigh with wound cleanser, pat dry, apply Silvadene to the wound base, then apply Xeroform (a fine mesh gauze occlusive dressing impregnated with petrolatum and 3 percent Xeroform) cut-to-fit the wound base, cover with ABD pad (a gauze dressing that absorbs fluid from large or heavily draining wounds), and secure with netted retention gauze or rolled gauze and tape once daily and as needed.<br><br>A nursing note for Resident 1, dated July 4, 2024, revealed that the resident's daughter was provided an update on the degree of the burns and current appearance as well as the treatment changes.<br><br>A statement completed by a resident's visiting family member, dated June 30, 2024, revealed that Dietary Server 1 came over and sat the coffee down with no lid. Resident 1 picked up the cup, took a drink, and stated, That's hot. She set the cup down and then spilled it soon after.<br><br>A statement completed by Dietary Server 1, dated June 30, 2024, revealed that he got Resident 1 a cup of coffee and set it down in front of her.<br><br>A statement completed by Registered Nurse 2, dated June 30, 2024, revealed that she was called to Resident 1's room for reports of a burn. The resident was in bed with three burn areas, two on her stomach measuring 6 cm by 1 cm and 10 cm by 6 cm, and the third area was on the resident's right upper thigh and down between her legs and measured 30 cm by 10 cm. Registered Nurse 2 went to the kitchen, asked for the coffee pot that the resident was served from, and the temperature of the coffee was 164.1 degrees F. While temping the coffee in the pot Dietary Server 1 said, The pot has been there for hours. Registered Nurse 2 asked him if the resident had a lid, and he said no.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A statement completed by Dietary Aide 3, dated July 1, 2024, revealed that on June 30, 2024, she worked breakfast and lunch. She made coffee during lunch about 12:30 p.m., which she did not temp, and Resident 1 got coffee at dinner and got burnt. It was from the same pot that she had made for lunch. She knew that she should have temped it and that it should not be served unless it was 140 degrees F. She did not temp it because she was busy then forgot.<br><br>A statement completed by the Dining Services Director, dated June 30, 2024, revealed that on June 30, 2024, at approximately 5:30 p.m. he spoke with Dietary Server 1 via phone. He was informed that Dietary Server 1 had used a pot of coffee previously brewed for lunch and did not log the temperature of the coffee being served. He was aware of the requirement to log the temperatures of hot beverages and acknowledged that coffee needs to be under 140 degrees F. He confirmed that he did not brew the coffee that caused the burn, and it was from lunch.<br><br>A statement completed by the Assistant Dining Services Director, dated July 1, 2024, revealed that she called Dietary Server 1 and asked why he did not take the temperature of the coffee, and he said that he forgot. The coffee pot out front of the counter was empty, so he pulled the full pot that was there already from the back of the counter, then placed the empty one to be brewed.<br><br>A statement completed by the Dining Services Director, dated July 3, 2024, revealed that he spoke with Dietary Server 1 on the phone on July 3, 2024, at 8:30 a.m. He had asked him if he had heard Resident 1 state that the coffee he served her was hot. He said that he did not hear the resident or anyone else make that statement.<br><br>An investigation summary revealed that on June 30, 2024, at 4:15 p.m. Resident 1 was observed by a visitor to have spilled coffee on her lap. The visitor notified staff, who called the registered nurse to assess the resident. The resident was noted to have three reddened areas to her right upper thigh (30 cm by 10 cm), her right lower quadrant (10 cm by 6 cm), and a separate area next to her right lower quadrant (6 cm by 1 cm). The provider was notified and ordered Silvadene Cream to the area and pain control with Tylenol (an over-the-counter pain medication) as needed. Upon reassessment at 7:00 p.m. the resident was noted to have three fluid-filled blisters to the right thigh, each measuring 2 cm by 2 cm. The registered nurse supervisor temped the coffee from the carafe that Resident 1 was served from, and it was temped at 165 degrees F. An investigation was initiated as the maximum temp for hot beverages per facility policy is 140 degrees F.<br><br>(continued on next page) |

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

The investigation revealed that Dietary Server 1 served Resident 1 coffee that was above maximum temperature of 140 degrees F per policy. This occurred at the start of the evening meal on Sunday June 30, 2024. The resident received three burns after spilling the coffee on herself. A statement from Dietary Server 1 revealed that he should have temped the coffee prior to service. When asked why he did not temp the coffee he said, I forgot. Dietary Server 1 stated that the coffee in question was brewed at lunch. Dietary Server 1 was placed on administrative leave on June 30, 2024. Dietary Server 1 was last educated on the hot beverage policy on May 23, 2024. Dietary Aide 3 worked breakfast and lunch on June 30, 2024. It was determined that she had brewed the pot of coffee in question (at lunch time) that was later served to the resident several hours later. Dietary Aide 3 was asked if she brewed and temped the coffee at lunch time, to which she responded that she did brew the coffee, got busy and then forgot to temp it. Dietary Aide 3 was placed on administrative leave on July 1, 2024. Dietary Aide 3 was last educated on the hot beverage policy on May 24, 2024. Resident 1 was served coffee that was over the maximum temperature of 140 degrees F. The resident spilled the coffee on her lap and sustained three burns to her abdomen and right thigh. Dining staff did not follow the procedure for temping coffee prior to the meal service. Dietary Aide 3 and was terminated on July 5, 2024.

Interview with the Nursing Home Administrator and the Assistant Director of Nursing on July 22, 2024, at 2:40 p.m. confirmed that Dietary Aide 3 did not follow the facility's policy for temping hot beverages prior to the meal service.

Following the incident/investigation on June 30, 2024, the facility's corrective actions included:

Dietary Server 1 and Dietary Aide 3 were both placed on administrative leave. Dietary Aide 3 was terminated from employment at the facility July 5, 2024.

The coffee and hot water were removed from the units and discarded on June 30, 2024.

New pots of coffee were brewed, and the temperatures were verified to be under 140 degrees F before serving.

The next morning two staff brewed and temped the coffee made for the breakfast meal on July 1, 2024, and confirmed that the coffee was at 140 degrees F before service.

Coffee makers will be removed from the units and the coffee, as well as any hot beverages, will be made in the main kitchen and will be temped by two staff, verifying that the temperature is 140 degrees F or less.

Residents will be served hot beverages with coffee lids.

Dietary staff were re-educated on the facility's hot beverage policy, temperature logs, and educated on the new process for serving hot beverages, which was completed on July 1, 2024.

The nursing staff was educated on the new procedure that coffee is only brewed in the main kitchen and that the temperature is verified by two individuals.

Audits to identify any issues with the temperatures of hot beverages were started.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395530 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Presbyterian Homes-Presby | 220 Newry Street<br>Hollidaysburg, PA 16648 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The results of these audits will be brought to the Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary.<br><br>Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F689 on July 1, 2024.<br><br>28 Pa. Code 201.14(a) Responsibility of Licensee.<br><br>28 Pa. Code 201.18(b)(1)(e)(1) Management.<br><br>28 Pa. Code 201.24(e)(4) Admission Policy.<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing Services. |