STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395533	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windy Hill Village of Presbyterian Homes	100 Dogwood Drive Philipsburg, PA 16866

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 44738 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to accommodate resident needs regarding the accessibility of a call bell for two of 17 residents reviewed (Residents 25 and 53). Findings include: Clinical record review for Resident 25 revealed a diagnoses list that included: a need for assistance with personal care, weakness, and contracture of the muscles. A current care plan for Resident 25 revealed the resident is at risk for falling related to gait abnormality, a history of pain, incontinence, and other medical areas. An intervention listed on the care plan included to keep the call bell in reach. Observation of Resident 25 on July 31, 2024, at 9:48 AM revealed he was in bed. The call bell was observed not within reach with the call bell cord tucked between the resident's right side rail and mattress and the activator hanging down under the bed almost touching the floor. Observation of Resident 25 on August 1, 2024, at 11:10 AM revealed he was in bed. The call bell was observed out of his reach with the call bell cord tucked between the resident's right side rail and mattress and the activator was on the floor. A concurrent interview with Resident 25 revealed the resident replied, Good question, when asked if he knew where the call bell was. The resident further attempted to access the call bell and was unable. Employee 3, registered nurse, was advised of the finding for Resident 25 on August 1, 2024, at 11:13 AM and further assisted the resident with accessing the call bell. Clinical record review for Resident 53 revealed a diagnoses list that included: a need for assistance with personal care, dementia, age-related physical debility, and muscle weakness. A current care plan for Resident 53 revealed the resident is at risk for falling related to gait abnormality, cognition deficit, incontinence, attempting to crawl out of bed, and multiple other medical issues. An intervention listed on the care plan included to keep the call bell in reach. (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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident 53 on August 1, 2024, at 9:17 AM and 11:14 AM revealed she was in bed. The call bell was observed out of her immediate reach with the activator hanging down below the bed and almost touching the floor. Employee 3, registered nurse, was advised of the finding for Resident 53 on August 1, 2024, at 11:17 AM. The above information for Residents 25 and 53 were reviewed with the Nursing Home Administrator and Director of Nursing on August 1, 2024, at 2:05 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 19719 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide a written notice of transfer that included all the written components to the resident and/or the resident's responsible party for two of seven residents reviewed (Resident 8 and 13). Findings include: Review of Resident 8's clinical record revealed that the facility transferred her to the hospital on July 23, 2024. Resident 8 was still in the hospital at the time of the full health survey. There was no documented evidence that that the facility attempted to provide Resident 8's responsible party with a transfer notice that included all the required contents: State long term care appeal agency or contact and address information for the Office of the State Long-Term Care Ombudsman including email address. Observation on August 2, 2024, at 12:15 PM confirmed that Resident 8's transfer forms were still sitting in an envelope at the facility's front desk. Interview with the Director of Nursing on August 2, 2024, at 12:55 PM confirmed that if a resident's responsible party is unable to be contacted regarding the transfer, then the notice is sent out via the mail. Review of Resident 13's clinical record revealed that the facility transferred her to the hospital on May 31, 2024. There was no documented evidence that the facility provided Resident 13's responsible party with a transfer notice that included all the above components. Interview with Employee 1, admissions, on August 2, 2024, at 9:18 AM confirmed the above findings for Resident 13. 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights

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NAME OF PROVIDER OR SUPPLIER: Windy Hill Village of Presbyterian Homes		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 Dogwood Drive Philipsburg, PA 16866	

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 19719 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide a written notice of the facility's bed hold policy to the resident or responsible party for two of seven residents reviewed for hospitalization s (Residents 8 and 13). Findings include: Review of Resident 8's clinical record revealed that she was admitted to the hospital on July 23, 2024. Resident 8 was still hospitalized at the time of the full health survey. There was no documented evidence in Resident 8's clinical record to indicate that the facility provided her responsible party written information on the facility's bed hold policy. Observation on August 2, 2024, at 12:15 PM confirmed that Resident 8's bed hold forms were still sitting in an envelope at the facility's front desk. Interview with the Director of Nursing on August 2, 2024, at 12:55 PM confirmed that if a resident's responsible party is unable to be contacted regarding a transfer, then the notice is sent out via the mail. Review of Resident 13's clinical record revealed that she was admitted to the hospital on May 31, 2024. There was no documented evidence in Resident 13's clinical record to indicate that the facility provided her responsible party written information on the facility's bed hold policy. Interview with Employee 1, admissions, on August 2, 2024, at 9:18 AM confirmed the above findings for Resident 13. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(f) Resident rights

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 36798 Based on clinical record review and staff interview, it was determined that the facility failed to identify and refer a resident with a diagnosed mental disorder for level II review for one of one resident reviewed for PASRR (Pre-Admission Screening and Resident Review) compliance (Resident 10). Findings include: The PA-PASRR-ID form (Pennsylvania Pre-Admission Screening and Resident Review; PA-PASRR, federally required form to help ensure that all individuals are evaluated for serious mental disorder and/or intellectual disability to ensure applicants are not inappropriately placed in nursing homes for long term care) dated February 2016 and revised in September 2018, lists examples of serious mental illness including psychotic disorder and schizophrenia. The revised PA-PASRR-ID bulletin number 01-14-13, 03-14-10, 07-14-01, 55-14-01 dated March 1, 2014, revealed that nursing facilities are responsible for assuring the accuracy of information reported on the PA-PASRR-ID form. If the individual has a change in condition that affects target status a PA-PASRR-EV (Level II) will need to be completed. Nursing facilities will communicate the need to have a PA-PASRR-EV done by notifying the Department's (Department of Public Welfare, now the Department of Human Services) Office of Long-Term Living, Bureau of Quality and Provider Management, Division of Nursing Facility Field Operations via the MA 408 form (a form used to notify the Department of a change in a resident's target status). Review of the MA 408 form dated March 2020 indicates that with a change in a resident's condition (any change in the individual's condition that affects the target status) the nursing facility is to send or fax the original form within 48 hours to their (Department of Public Welfare's) nursing facility field operations office. Review of Resident 10's clinical record revealed a PA-PASARR dated November 24, 2004, that documented no disorders that would trigger a level II review. The assessment indicated that there were no diagnoses of neurocognitive disorders or serious mental illness, a level II review was not necessary, and to admit Resident 10 as a regular admission. The form was reviewed by the Department of Human Services (DHS) on January 5, 2005. Resident 10's clinical record identified her as having a diagnosis of paranoid schizophrenia (a mental disorder where a person experiences fear that feeds into their delusions and hallucinations) that was added to her plan of care on January 20, 2005. There was no evidence that the facility notified the appropriate agencies related to Resident 10's identified target diagnosis. Interview with the Director of Nursing on August 2, 2024, at 9:30 AM acknowledged the above findings for Resident 10. 28 Pa. Code 201.14 (a) Responsibility of Licensee 28 Pa. Code 211.5(f)(iv)(vi) Medical records (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(3)(5) Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 36798 Based on clinical record review and staff interview, it was determined that the facility failed to identify triggers related to a resident's diagnosis of Post-Traumatic Stress Disorder, to provide culturally, competent, trauma-informed care and eliminate or mitigate re-traumatization for one of one resident reviewed (Resident 10). Findings include: Clinical record review for Resident 10 revealed a current care plan entitled Behavioral Symptoms that identified her as having PTSD (Post Traumatic Stress Syndrome, a mental and behavioral disorder that develops from experiencing a traumatic event). The care plan goal was that Resident 10 would remain stable with interventions and medications as ordered. Further review of her care plan revealed that the facility failed to identify triggers that may retraumatize her related to her diagnosis of PTSD. A physician's progress note provided to the surveyor on August 2, 2024, at 9:30 AM dated November 24, 2004, indicated that Resident 10 was admitted from a personal care home after an alleged rape by another resident. The note also indicated that Resident 10 was in a motor vehicle accident in 1987 and suffered head trauma. Neither of the two events were identified in her plan of care as the cause of her PTSD but were provided to the surveyor as the identified cause of Resident 10's PTSD. Interview with the Director of Nursing on August 2, 2024, at 9:45 AM confirmed the above noted findings related to Resident 10's diagnosis of PTSD. The facility failed to identify care plan triggers that may retraumatize Resident 10 related to her diagnosis of PTSD. 28 Pa Code 211.12 (d)(3)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38839 Based on observation and staff interview, it was determined the facility failed to store food and maintain food service equipment in a safe and sanitary manner and prevent the potential for food contamination in the facility's main kitchen. Findings include: An observation of the facility's main kitchen on July 30, 2024, at 9:37 AM revealed the following: A speed rack located beside the ovens was observed with trays of potatoes, as well as another tray at the bottom of the rack holding a container with a variety of equipment such as spatulas, spoons, labels, and pens. The tray contained dried spills and food splatter. A drawer unit under a preparation table across from the ovens was dusty, contained dried food debris, and food splatter. Lower shelves of preparation and storage tables throughout the kitchen where food preparation equipment was stored were observed with dust, crumbs, and dried spills. Flooring throughout the kitchen under preparation tables, steam tables, oven, coolers, and along wall edges, was observed with dirt and debris buildup, dried food, wrappers, soiled plastic spoon, and dried spills. A three-tier black cart beside the dishwashing area was observed with clean plate bases and lids. The cart handles and edges of the shelves were soiled with debris and dried food. A table where open boxes of sugar packets and hot chocolate packets were stored contained significant dust and debris behind and around the containers. The floor of the walk-in cooler contained a buildup of dirt and debris. The flooring in the dry storage area was significantly worn with multiple cracked tiles. Employee 3, production manager, was observed walking in and out of the kitchen multiple times during the above observations. Employee 3 had a full beard without any covering. A follow up observation in the main kitchen on August 1, 2024, at 12:04 PM revealed Employee 4 and Employee 5, dietary aides, working in the kitchen production area preparing lunch service trays. Employee 4 and Employee 5 both had visible facial hair without any protective covering. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on August 1, 2024, at 2:02 PM. 483.60 (i)(2) Food store, distribute, maintain, sanitary (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Previously cited 8/25/23 28 Pa. Code 201.14 (a) Responsibility of licensee

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 36798 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident received or was offered pneumococcal conjugate vaccines for two of five residents reviewed for immunization concerns (Residents 7 and 168). Findings include: Clinical record review for Resident 7 revealed that the facility admitted her on March 12, 2024. Review of her immunizations in her clinical record revealed that there was no documentation related to the pneumococcal conjugate vaccines (vaccines administered to prevent pneumonia). Clinical record review for Resident 168 revealed that the facility admitted her on July 17, 2024. Review of her immunizations in her clinical record revealed that there was no documentation related to the pneumococcal conjugate vaccines. The Director of Nursing was made aware of concerns with Resident 7 and 168's pneumococcal vaccinations on August 2, 2024, at 1:01 PM. The facility failed to ensure the Residents 7 and 168 received the appropriate vaccinations as recommended. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services