STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395539	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anne Home	685 Angela Drive Greensburg, PA 15601

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 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48941 Based on review of facility policies, clinical records, and investigation documents, as well as staff and resident interviews, it was determined that the facility failed to ensure that residents were free from abuse and neglect for one of seven residents reviewed (Resident 1) who was transferred incorrectly, resulting in a fracture. Findings include: The facility's abuse policy, dated October 13, 2023, indicated that residents have the right to be free from any verbal, sexual, physical, and mental abuse; corporal punishment; involuntary seclusion; exploitation; and misappropriation of resident property. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff or other agencies serving the individual, family members or legal guardians, friends or other individuals. The intent of the policy is to develop and maintain a proactive process of detection and prevention of resident mistreatment, neglect, abuse, and misappropriation of property. Any staff member found guilty of abusing, neglecting or mistreating residents will be discharged immediately. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated July 9, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, was dependent for transfers, and had diagnoses that included Alzheimer's disease and osteoporosis (condition that weakens the bones and increases risk for fracture). The current activities of daily living care plan for Resident 1 indicated that the resident required the use of a mechanical lift for transfers. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	A facility investigation document, dated August 6, 2024, revealed that Nurse Aide 1 (an agency nurse aide) called the facility on August 6, 2024, and reported to Registered Nurse 3 that a fall occurred on August 5, 2024, involving Resident 1. Nurse Aide 1 reported that she went into Resident 1's room on August 5, 2024, and saw her on the floor and Nurse Aide 2 (an agency nurse) was in the resident's room. Nurse Aide 1 stated that Nurse Aide 2 asked her to help pick the resident up. They picked the resident up off the floor and put her in her wheelchair and did not report it to the licensed practical nurse or the registered nurse. The resident was assessed following the report of the incident on August 6, 2024, and she was complaining of severe pain to her left leg with transfers and movement. Her left leg was swollen. The physician was notified, and an x-ray was ordered of the resident's left hip and knee. The x-ray results revealed a minimally impacted supracondylar fracture of the distal left femur. The physician was notified, and the resident was sent to the hospital. A written statement from Registered Nurse 3, dated August 6, 2024, revealed that on August 6, 2024, she received a phone call from Nurse Aide 1, indicating that she had to report an incident that occurred August 5, 2024. She indicated that before breakfast, between 7:00 a.m. and 8:00 a.m., she heard yelling and went into Resident 1's room and found Nurse Aide 2 in the room and Resident 1 was on the floor. Nurse Aide 1 stated that Nurse Aide 2 said the resident did not fall and asked her to help her get the resident up. They both assisted the resident off the floor and into her wheelchair. Neither nurse aide reported the incident to the licensed practical nurse on the unit or the registered nurse supervisor. Registered Nurse 3 assessed the resident after the call indicating that the resident was lying in bed and comfortable at rest but had pain with movement and transfers. She noted the resident's left leg was slightly more swollen than the right leg, and the resident was unable to explain what happened due to her diagnosis of Alzheimer's dementia. She indicated that the medical director was notified, x-rays were ordered to the left knee and leg, the daughter was called and updated, and the Director of Nursing was notified. Human resources contacted the staffing agency and informed them that Nurse Aide 2 was not to return to the facility. Registered Nurse 3 stated that she called Licensed Practical Nurse 4, who revealed that she was not informed of any incident on August 5, 2024. Licensed Practical Nurse 4 also indicated the Resident 1 did not have a hoyer lift pad underneath her at breakfast. Registered Nurse 3 indicated that she was the registered nurse on duty on August 5, 2024, and no nurse aide reported that the resident was on the floor. Registered Nurse 3 indicated that the x-rays were obtained showing a minimally impacted supracondylar fracture of the distal left femur, the medical director was notified, the daughter and Director of Nursing was notified, and the resident was sent to the hospital. Registered Nurse 3 indicated that she called and made a report to the after-hours Area Agency on Aging (AAA). A written statement from Nurse Aide 1, dated August 6, 2024, at 1:41 p.m., revealed that on August 5, 2024, between 7:00 a.m. and 8:00 a.m., while she was trying to find someone to give her report, she heard yelling from a room. She went into Resident 1's room and found Nurse Aide 2 in the resident's room and the resident was on the floor. (continued on next page)

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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 Level of Harm - Actual harm Residents Affected - Few	A written statement from Nurse Aide 2, dated August 7, 2024, at 3:50 p.m., indicated that she started her shift at 6:30 a.m. on August 5, 2024, and when she got there, she went to the Director of Nursing's office, and they told her to go to a certain floor and the night shift came up to the office were she and another nurse aide were waiting to get report. She indicated that she did not get report and it was starting to get late and breakfast was coming, so she started with Resident 1 and went into her room and asked her if she was ready to get up and she said yes. She got her dressed, set her up at the edge of the bed, got her fully dressed, and got the chair close to her bed where she got her up to stand and pivot. She indicated that she did not see Resident 1's hoyer sling in the room at all and did not know she was a hoyer lift, so she helped her stand up and when she did, she fumbled to the floor. She indicated that she helped the resident to the floor and put a pillow behind her, and before she could put the pillow behind her, Nurse Aide 1 came in. Nurse Aide 2 indicated she needed help. Nurse Aide 2 grabbed the resident's arms and she grabbed her legs and lifted her to her wheelchair. She indicated that they both went to tell the nurse and report it to her, and she said she will report it once they got the rest of the people done for breakfast. She indicated that hours later, Nurse Aide 1 went to her and said that Resident 1 was a hoyer lift and she never knew. Description of follow up-action, (as documented on the event report) for Resident 1, dated August 7, 2024, revealed that Nurse Aide 2 was interviewed and indicated that she reported Resident 1's fall to the unit nurse; however, the unit nurse denied being notified. Nurse Aide 1, who was Nurse Aide 2's partner, reported the incident the next day indicating that she thought Nurse Aide 2 had not reported it. Failure to notify the licensed practical nurse who was assigned to Resident 1 was verified. Failure to follow the care plan for Resident 1 to transfer with assist of two or hoyer lift was verified. Review of investigation documentation revealed that Nurse Aide 2 received abuse and neglect training on March 19, 2024. An interview with the Director of Nursing on August 28, 2024, at 5:00 p.m. revealed that Nurse Aide 1 reported Resident 1's fall on August 6, 2024, because she did not believe Nurse Aide 2 reported it. Nurse Aide 2 was not permitted back to the facility. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(e)(1) Management. 28 Pa. Code 201.29(a)(j) Resident Rights. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 28177 Based on review of clinical records and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that staff immediately reported a fall with injury for one of seven residents reviewed (Resident 1). Findings Include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated July 9, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, was dependent for transfers, and had diagnoses that included Alzheimer's disease and osteoporosis (condition that weakens the bones and increases risk for fracture). The current activities of daily living care plan for Resident 1 indicated that the resident required the use of a mechanical lift for transfers. Investigation documentation provided by the facility revealed that Nurse Aide 1 (an agency nurse aide) called the facility on August 6, 2024, and reported to Registered Nurse 3 that a fall occurred on August 5, 2024, involving Resident 1. Nurse Aide 1 reported that she went into Resident 1's room on August 5, 2024, and saw the resident on the floor and Nurse Aide 2 (an agency nurse) was in the resident's room. Nurse Aide 1 stated that Nurse Aide 2 asked her to help pick the resident up. They picked the resident up off the floor and put her in her wheelchair and did not report it to the licensed practical nurse or the registered nurse. Resident 1 was assessed following the report of the incident on August 6, 2024, and she was complaining of severe pain to her left leg with transfers and movement. Her left leg was swollen. The physician was notified, and an x-ray was ordered of the resident's left hip and knee. The x-ray results revealed a minimally impacted supracondylar fracture of the distal left femur. The physician was notified, and the resident was sent to the hospital. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A written statement from Registered Nurse 3, dated August 6, 2024, revealed that on August 6, 2024, she received a phone call from Nurse Aide 1 indicating that she had to report an incident that occurred August 5, 2024. She indicated that before breakfast, between 7:00 a.m. and 8:00 a.m., she heard yelling and went into Resident 1's room and found Nurse Aide 2 in the room and Resident 1 was on the floor. Nurse Aide 1 stated that Nurse Aide 2 said the resident did not fall and asked her to help her get the resident up. They both assisted the resident off the floor and into her wheelchair. Neither nurse aide reported the incident to the licensed practical nurse on the unit or the registered nurse supervisor. Registered Nurse 3 assessed the resident after the call indicating that the resident was lying in bed and comfortable at rest but had pain with movement and transfers. She noted the resident's left leg was slightly more swollen than the right leg, and the resident was unable to explain what happened due to her diagnosis of Alzheimer's dementia. She indicated that the medical director was notified, x-rays were ordered to the left knee and leg, the daughter was called and updated, and the Director of Nursing was notified. Human resources contacted the staffing agency and informed them that Nurse Aide 2 was not to return to the facility. Registered Nurse 3 stated that she called Licensed Practical Nurse 4, who revealed that she was not informed of any incident on August 5, 2024. Licensed Practical Nurse 4 also indicated the Resident 1 did not have a hoyer lift pad underneath her at breakfast. Registered Nurse 3 indicated that she was the registered nurse on duty on August 5, 2024, and no nurse aide reported that the resident was on the floor. Registered Nurse 3 indicated that the x-rays were obtained showing a minimally impacted supracondylar fracture of the distal left femur, the medical director was notified, the daughter and Director of Nursing was notified, and the resident was sent to the hospital. Registered Nurse 3 indicated that she called and made a report to the after-hours Area Agency on Aging (AAA). A written statement from Nurse Aide 1, dated August 6, 2024, at 1:41 p.m., revealed that on August 5, 2024, between 7:00 a.m. and 8:00 a.m., while she was trying to find someone to give her report, she heard yelling from a room. She went into Resident 1's room and found Nurse Aide 2 in the resident's room and the resident was on the floor. A written statement from Nurse Aide 2, dated August 7, 2024, at 3:50 p.m., indicated that she started her shift at 6:30 a.m. on August 5, 2024, and when she got there, she went to the Director of Nursing's office, and they told her to go to a certain floor and the night shift came up to the office were she and another nurse aide were waiting to get report. She indicated that she did not get report and it was starting to get late and breakfast was coming, so she started with Resident 1 and went into her room and asked her if she was ready to get up and she said yes. She got her dressed, set her up at the edge of the bed, got her fully dressed, and got the chair close to her bed where she got her up to stand and pivot. She indicated that she did not see Resident 1's hoyer sling in the room at all and did not know she was a hoyer lift, so she helped her stand up and when she did, she fumbled to the floor. She indicated that she helped the resident to the floor and put a pillow behind her, and before she could put the pillow behind her, Nurse Aide 1 came in. Nurse Aide 2 indicated that she needed help. Nurse Aide 2 grabbed the resident's arms and she grabbed her legs and lifted her to her wheelchair. She indicated that they both went to tell the nurse and report it to her, and she said she will report it once they got the rest of the people done for breakfast. She indicated that hours later, Nurse Aide 1 went to her and said that Resident 1 was a hoyer lift and she never knew. (continued on next page)

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