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	11/21/2024

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47819 Based on a review of facility policies, clinical records, and investigation reports, as well as observations and staff interviews, it was determined that the facility failed to ensure that the environment was free of accident hazards by failing to ensure that hot liquids were served at appropriate temperatures for two of five residents reviewed (Residents 2, 5) resulting in burns to the residents, and failed to ensure that temperatures of hot liquids were taken, per facility policy, prior to serving the hot liquids to the residents. The facility's failure also placed the current residents who will receive hot liquids in Immediate Jeopardy of the likelihood of serious bodily injury, harm, or death. Findings include: The facility policy regarding serving hot liquids, dated October 10, 2024, indicated that dining services will follow the tray assessment schedule and monitor random meals for the temperature of hot liquids prior to delivery to the resident. Temperatures upon delivery to the resident will not exceed 155 degrees Fahrenheit (F). For dining in the remote dining areas, the temperature of hot beverages and soups will be recorded by the dining room server at time of meal service. The temperature of hot liquids will not exceed 155 degrees F at time of delivery to the resident. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated August 31, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that include dementia, anxiety, and depression. A care plan for the resident, dated August 11, 2024, revealed that the resident required extensive assistance with her Activities of Daily Living (ADL's - they include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating) related to impaired mobility. A nursing note for Resident 2, dated November 13, 2024, revealed that the writer was called to the unit at 7:45 a.m. and that the resident had spilled hot coffee on herself. The resident was assessed, and redness was observed to her left upper thigh. No blistering was present, slight discomfort but no extreme pain. A cool compress was applied. When staff give Resident 2 hot liquids, the hot liquids are to be placed in a sippy cup with a lid. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A facility incident report for Resident 2, dated November 13, 2024, revealed that the writer was called to the unit at 7:45 a.m. because the resident had spilled hot coffee on herself. The resident was assessed, and redness was observed to her left upper thigh. No blistering was present. When the resident was interviewed, she stated ,I spilled my hot coffee. The hot water temperature was 149 degrees F when checked. However, there was no documented evidence that the temperature of Resident 2's hot coffee was checked prior to being served to her. Interview with the Assistant Nursing Home Administrator on November 21, 2024, at 4:25 p.m. confirmed that there was no documented evidence that the hot coffee was temped prior to the resident receiving it and there should have been. Observations in the [NAME] Courtyard dining room on November 21, 2024, at 11:55 a.m. revealed that Resident 2 was sitting at the dining room table. The Chef Manager came to the kitchen on the unit to temp the hot coffee, which was 171 degrees F. Nurse Aide 1 served the coffee to Resident 2 after it was temped at 171 degrees F, and Resident 2 was observed consuming the hot coffee out of her sippy cup. Interview with Dietary Manager on November 21, 2024, at 1:06 p.m., revealed that the acceptable range to serve coffee is between 145 and 155 degrees F. The Dietary Manager stated that the coffee machine that was currently in the [NAME] Courtyard kitchen and used during lunch was not the facility's coffee machine but one that staff had brought in on an unknown date. She stated that no temperature logs were being completed prior to serving the residents. A quarterly MDS assessment for Resident 5, dated August 19, 2024, revealed that the resident was understood and could understand others. A care plan for the resident, dated August 15, 2024, revealed that the resident required extensive assistance with her ADL's related to impaired mobility. A nursing note for Resident 5, dated August 30, 2024, revealed that the writer was called to the unit at 3:20 p. m. and that the resident was observed lying in bed and a red area was observed to her left upper thigh. The area measured nine centimeters (cm) by 20 cm. The resident stated, I was getting a drink of my hot tea and knocked the cup over. A cool compress was applied. When staff gives the resident hot liquids, they are to be placed in a cup with a lid. The resident was reassessed at 9:20 p.m. and she was resting in bed and had intact blisters observed to left upper thigh. A facility investigation report for Resident 5, dated August 30, 2024, revealed that the writer was called to the unit at 3:20 p.m. The resident was observed lying in bed and a red area was observed to her left upper thigh. The area measured nine centimeters (cm) by 20 cm. When the resident was reassessed, the resident had blisters. When the resident was interviewed, she stated, I was getting a drink of my hot tea and knocked the cup over. The hot water temperature was 185.1 degrees F when checked; however, there was no documented evidence that the temperature of Resident 5's hot tea was checked prior to being served to her. A wound physician's note for Resident 5, dated September 4, 2024, revealed that this was the initial wound encounter with the resident. Measurements of the resident's wound was 6.2 cm by 11.3 cm with no measurable depth. The wound was irregular shaped, full thickness, with mixed second-degree (involve the outer and middle layers of skin) and third degree (a serious wound that damages all three layers of your skin) burns of the resident's left thigh as a result from a coffee spill. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the Assistant Nursing Home Administrator on November 21, 2024, at 4:25 p.m. revealed that she spoke with the nurse who completed the investigation on Resident 5's coffee spill and said that she confirmed that temperature of the hot liquid was taken from the same machine that the resident's hot liquid was obtained from. Interview with the Nursing Home Administrator and the Assistant Nursing Home Administrator on November 21, 2024, at 6:35 p.m. revealed that Resident 5 must have been served the hot tea by nursing staff and that there was no documented evidence that the temperature was obtained prior to the resident receiving the hot tea. On November 21, 2024, at 4:30 p.m. the Nursing Home Administrator was given the Immediate Jeopardy template and informed that the health and safety of current residents were placed in Immediate Jeopardy due to the facility's failure of not obtaining hot liquid temperatures prior to serving to the residents. An immediate action plan was submitted and contained the following: The facility submitted and implemented an immediate action plan that included the facility will immediately review all daily temperature logs for the current dinner meal being served to ensure the temperature falls within current policy guidelines with all staff currently working. The facility will educate all Dining Service staff that the requirement of taking temperatures of hot beverages in the serving container prior to serving these beverages to the residents must be done prior to every meal and documented on the Daily Temperature Log. If the temperature of a hot beverage falls outside the range of 145 degrees Fahrenheit to 155 degrees Fahrenheit, do not serve the beverage until it cools down and is in these parameters. Daily monitoring of Daily Temperature Logs will be done by the Director of Dining Services or designee. The Director of Dining Services or designee will audit weekly for four weeks, then once a month for two months for any allegations of abuse or neglect emphasizing to all employees zero tolerance. Audits will include assessing whether the unit report sheets are up to date and that staff are utilizing these quick reference guides prior to initiating care. All findings will be reported to the Quality Assurance Performance Improvement Committee. If deficient practices are identified, additional corrective action will be taken. The Immediate Jeopardy was lifted on November 21, 2024, at 6:50 p.m. when it was confirmed that the facility had completed education for the current staff working in house and audits of the dinner meal hot coffee temperatures being within policy guidelines. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47819 Based on review of facility policies and information provided by the facility, as well as observations and staff interviews, it was determined that the facility failed to serve food items at appetizing temperatures. Findings include: The facility's policy regarding taste and temperature control, dated October 10, 2024, revealed that prior to the start of each meal period, there is an evaluation of the taste and temperature of food. Cold foods, such as milk, butter, ice cream, and juices are refrigerated during service or properly iced. Holding temperatures for hot foods will be 140 degrees Fahrenheit (F) or above. Holding temperatures for cold foods will be 40 degrees F or below. All foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit (F) (or as state regulation requires) for hot holding and less than 41 degrees F for cold food holding. Review of Resident Council meeting minutes, dated October 2024, revealed that the residents on the Villa [NAME] Unit complained about their food being cold on Thursdays and Fridays when the usual dietary aide was not there for the lunch and supper meals. Observations on the Villa [NAME] Unit kitchen on November 21, 2024, at 11:55 a.m. revealed that Dietary Worker 2 placed the prepared food items that she brought from the main kitchen into the steam table. She continued to prepare various items while the residents arrived in the dining room. At 12:15 p.m. once all the residents that eat in the dining room from the Villa [NAME] Unit were in the dining room, she removed three pans that contained white milk, water, and various juices in glasses with lids and no ice in the pans from the refrigerator and placed them on the counter above the steam table. She then began preparing the residents' meals that were in the dining room. After completing the residents that were in the dining room, she began preparing the meals for the residents who eat their meals in their rooms. At 12:52 p.m. the last resident that eats in their room was served. At 12:53 p.m. the temperature of the onion rings was 92 degrees F, the temperature of the Italian Wedding soup was 132.8 degrees F, and the temperature of the white milk was 55. 5 degrees F. The onion rings, and Italian Wedding soup were cool to taste and not palatable. The white milk was warm to taste and not palatable. Interview with the Chef Manager at the time of the observation confirmed that the food was not served at a palatable temperature. 28 Pa. Code 201.18(b)(1)(2)(e) Management. 28 Pa. Code 211.6(c) Dietary Services.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47819 Based on review of job descriptions and the deficiencies cited during the current survey, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to assume responsibility for effective management of the facility to ensure that the facility operated in compliance with state regulations and codes by not ensuring that hot liquids were served at appropriate temperatures, without which the residents health and safety are jeopardized for two of five residents reviewed (Resident R2, R5). Findings include: The job description for the NHA, dated May 4, 2021, indicated that the DON is to direct the functions of the Nursing Department in the delivery of care to residents according to accepted professional standards and in accordance with St. [NAME] Home's ethical requirements as described in our Mission, Vision, Value, Pledge and Fundamental Commitment statements found in the Code of Corporate Compliance. The NHA must meet all standards of performance and adhere to all applicable policies, procedures, and regulations. The NHA must perform all functions with or without accommodations in a manner that poses no direct threat to him/herself or to others. The position description for the DON, dated July 12, 2019, indicated that the DON is to direct the functions of the Nursing Department in the delivery of care to residents according to accepted professional standards and in accordance with St. [NAME] Home's ethical requirements as described in our Mission, Vision, Value, Pledge and Fundamental Commitment statements found in the Code of Corporate Compliance. The registered nurse must meet all standards of performance and adhere to all applicable policies, procedures, and regulations. The registered nurse must perform all functions with or without accommodations in a manner that poses no direct threat to him/herself or to others. The deficiencies cited under the Code of Federal Regulatory Groups for Long-Term Care, 483.25(b)(1)(2) Free of Accident Hazards/Supervision/Devices (F689), revealed that the NHA and DON failed to fulfill their essential job duties for ensuring that the residents' environment remained free of accident hazards. Refer to F689. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.