

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395552	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/25/2024
NAME OF PROVIDER OR SUPPLIER  Bethlen Hm of the Hungarian Rf of America		STREET ADDRESS, CITY, STATE, ZIP CODE 66 Carey School Road Ligonier, PA 15658	

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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46994</b></p> <p>Based on a review of facility policies, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure that a resident's baseline care plan included information regarding the resident's immediate care needs for one of six residents reviewed (Resident 3).</p> <p>Findings include:</p> <p>A facility policy for baseline care plans, dated December 22, 2023, revealed that the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will be developed within 48 hours of a resident's admission.</p> <p>Review of clinical records for Resident 3 revealed that he was admitted to the facility on [DATE], with a diagnosis of muscle wasting, Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors), and altered mental status.</p> <p>Physician's orders for Resident 3, dated March 11, 2024, included orders for the resident to receive 0.25 milligrams (mg) of risperidone (an antipsychotic medication) in the morning for mood, 0.5 mg of risperidone at bedtime for mood, and 0.5 mg of clonazepam (used to treat anxiety) every 12 hours as needed for agitation.</p> <p>There was no documented evidence that a baseline care plan included information regarding the resident's care needs related to receiving an antipsychotic or antianxiety medication.</p> <p>Interview with the Director of Nursing on March 25, 2024, at 2:42 p.m. confirmed that Resident 3's baseline care plan did not include receiving antipsychotic or antianxiety medications and should have.</p> <p>28 Pa. Code 211.12(d)(1) Nursing Services.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 19102</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a care plan was developed for discharge planning for three of six residents reviewed (Residents 1, 4, 6).</p> <p>Findings include:</p> <p>The facility's policy regarding care plans, dated December 22, 2023, indicated that an interdisciplinary team, in coordination with the resident, his/her family or representative (sponsor), would develop and maintain a comprehensive care plan for each resident. The comprehensive care plan would be designed to incorporate identified problem areas; incorporate risk factors associated with identified problems; build on the resident's strengths; reflect treatment goals and objectives in measurable outcomes; identify the professional services that are responsible for each element of care; prevent declines in the resident's functional status and/or functional levels; and enhance the optimal functioning of the resident by focusing on a rehabilitative program.</p> <p>A social service note, dated February 13, 2024, at 8:20 a.m. revealed that Resident 1 was admitted to the facility from the hospital on February 12, 2024. A diagnosis list, dated February 12, 2024, revealed that the resident had a fractured femur (large bone of leg) that required repair. A physician's progress note, dated March 11, 2023, revealed that the resident could be discharged on [DATE].</p> <p>A Discharge Plan of Care, dated March 11, 2024, revealed that the resident was to be discharged with home health nursing, physical and occupational therapy, and home health aide, and she was to follow up with her primary care physician. A nursing note, dated March 11, 2024, at 3:53 p.m., revealed that Resident 1 was discharged in the care of her daughter.</p> <p>There was no documented evidence that a care plan related to discharge planning was developed for Resident 1.</p> <p>A physician progress note, dated February 21, 2024, revealed that Resident 4 was admitted to the facility on [DATE], with a right thigh wound after she presented with a fever and chills and chronic right lower extremity cellulitis (bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin). A physician's progress note, dated March 12, 2024, revealed that the resident could be discharged on [DATE], with home health nursing, physical and occupational therapy, and home health aide, and she was to follow up with her primary care physician.</p> <p>A Discharge Plan of Care for Resident 4, dated March 12, 2024, revealed that the resident was to be discharged on [DATE]. A nursing note, dated March 14, 2024, at 10:19 a.m., revealed that the resident was discharged home with home health services, and her appointments, medications, and wound care were reviewed with her. Her primary care physician and home health were notified.</p> <p>There was no documented evidence that a care plan related to discharge planning was developed for Resident 4.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note, dated November 28, 2023, at 11:00 p.m. revealed that Resident 6 was admitted to the facility from the hospital, and a diagnosis list, dated November 28, 2023, included diagnoses that included a pulmonary embolism (blood clot in the lung).</p> <p>A Discharge Plan of Care for Resident 6, dated December 22, 2023, revealed that the resident was to be discharged on [DATE], with home health nursing, physical and occupational therapy, and home health aide, and he was to follow up with her primary care physician. A nursing note, dated December 25, 2023, at 2:56 p. m., revealed that the resident was discharged from the facility and the medications and discharge summary were reviewed with the resident and his daughter.</p> <p>There was no documented evidence that a care plan related to discharge planning was developed for Resident 6.</p> <p>Interview with the Director of Nursing on March 25, 2024, at 2:48 p.m. confirmed that Residents 1, 4 and 6 did not have care plans developed for discharge planning and should have.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		