STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395552	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlen Hm of the Hungarian Rf of America	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42079 Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that an assessment was completed by a professional (registered) nurse after an injury occurred for one of 10 residents reviewed (Resident 2). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. A facility policy, dated November 27, 2024, regarding accidents and incidents, indicated that falls require an incident and accident reports, with the nurse entering the information to the appropriate form or system within 24 hours of the occurrence and will document all pertinent information. The supervisors or other designee will be notified of the incident or accident. Any injuries will be assessed by the licensed nurse or practitioner, and the affected individual will not move until safe to do so. A quarterly minimum data set (MDS) assessment (mandated to assess the resident abilities and care needs) for Resident 2, dated October 30, 2024, revealed that the resident was usually understood and could usually understand others, was moderately cognitively impaired, required supervision and touch assistance with ambulation and transfers, and had wandering behaviors. A witnessed fall investigation and nurse's note completed by Licensed Practical Nurse 2, dated December 6, 2024, revealed that while receiving shift report Resident 2 attempted to sit in front of the piano in front of the nurse's station, but missed the stool and landed on her buttocks on the floor. There was no documented evidence in Resident 2's clinical record to indicate that a registered nurse assessment was conducted for Resident 2's fall. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395552	A. Building B. Wing	12/30/2024

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Licensed Practical Nurse 2 on December 30, 2024, at 5:40 p.m. revealed that he and the other licensed practical nurse who was going off shift witnessed the fall, and they responded immediately, but does not recall a registered nurse assessing Resident 2. An interview with Director of Nursing on December 30, 2024, at 2:27 p.m. confirmed that there was no documented evidence that a registered nurse assessment was completed after Resident 2 fell on [DATE], and there should have been. She explained that there have been many call offs, and she has been covering shifts and working the floor in addition to her Director of Nursing duties 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42079 Based on review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of four residents reviewed (Resident 3). Findings include: A facility policy, dated November 27, 2024, regarding accidents and incidents, indicated that falls require an incident and accident reports, with the nurse entering the information to the appropriate form or system within 24 hours of the occurrence and will document all pertinent information. The documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions. A quarterly minimum data set (MDS) assessment (mandated to assess the resident abilities and care needs) for Resident 3, dated October 21, 2024, indicated that the resident was sometimes able to understand others; was sometimes understood by others; was severely cognitively impaired; required supervision and touch assistance with ambulation, bed mobility, and transfers; required substantial assistance with hygiene, toileting, and dressing;had diagnoses that included Alzheimer's disease and wandering behaviors. A care plan for Resident 3, dated February 5, 2024, indicated that she was a risk for falls or injury. A fall investigation by Licensed Practical Nurse 1, dated December 24, 2024, revealed that Resident 3 was walking behind staff after completion of morning care. Resident 3 fell backwards onto her buttocks in the bathroom doorway with her walker still standing. A review of Resident 3's clinical record revealed no documented evidence of the resident's fall or an assessment by a registered nurse. Interview with Licensed Practical Nurse 1, dated December 30, 2024, at 3:33 p.m., indicated that she and the registered nurse on duty assessed Resident 3 following the fall on December 24, 2024. She confirmed that she did not write an additional nursing note in the clinical record because the investigation should have linked to the progress notes. The registered nurse should have written an additional note following the incident. Interview with the Director of Nursing on December 30, 2024, at 2:27 p.m. confirmed that there was no documented evidence of Resident 3's fall or assessment by a registered nurse in the clinical record, and there should have been. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(5) Nursing Services.