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	08/15/2024

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 48941 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident and/or resident representative had an opportunity to develop an advance directive or assist in formulating an advance directive for one of 32 residents reviewed (Resident 11). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 11, dated July 5, 2024, revealed that the resident was cognitively impaired and had absence of speech; However, the MDS indicated that she had no impairment with short and long-term memory and had some difficulty making decisions in new situations only. She was dependent with care needs and had diagnoses that included hemiplegia and hemiparesis (paralysis or weakness to one side of the body due to brain injury), cerebral infarction (lack of blood supply to the brain resulting in brain death to parts of the brain), and aphasia (a disorder that affects speaking or understanding language) due to a stroke. Review of Resident 11's medical records indicated that she did not have advance directives. There was no documented evidence in the resident's medical record that indicated the resident and/or her representative was informed of their rights to develop advance directives, no documented evidence that the resident and/or her representative was provided the opportunity and assistance to formulate an advance directive, and no documented evidence that advanced directives were addressed with the resident and/or resident representative periodically throughout her course of stay. Interview with the Nursing Home Administrator on August 14, 2024, at 9:20 a.m. confirmed that there was no evidence in Resident 11's medical records that indicated the resident and/or her representative was informed of their rights to develop advance directives, no documented evidence that the resident and/or her representative was provided the opportunity and assistance to formulate an advance directive, and no documented evidence that advanced directives were addressed with the resident and/or resident representative periodically throughout her course of stay. 28 Pa. Code 201.29(a)(d) Resident Rights.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48809 Based on observations and staff interviews, it was determined that the facility failed to provide a clean and homelike environment. Findings include: Observations in the lounge area on the 400 hall on August 12, 2024, at 11:15 a.m. revealed a five-gallon bucket on a cart containing old food scraps. Observations in the 300, 400, and 500 halls on August 14, 2024, at 12:26 p.m. revealed a five-gallon bucket with food scraps in it on each hallway. In the 500 hallway the bucket on a cart was at the beginning of the hallway across from the nurses' station, in the 300 hall the bucket was halfway down the hallway in front of resident rooms, and in the 400 hallway the bucket was in the lounge area directly behind a resident who was sitting on a couch eating lunch. Staff are scraping leftover food into each of the buckets on the hallways and placing the dishes under the bucket on the cart. Interview with Nurse Aide 1 on August 14, 2024, at 12:45 p.m. revealed that the buckets were disgusting and embarrassing, that family members have made statements regarding the buckets full of old food being left in the hallways and in the lounge area, and that they should not be scraping the plates into buckets in the resident's lounge areas and in living areas. Interview with Registered Nurse 2 on August 14, 2024, at 12:26 p.m. revealed that kitchen staff put an uncovered five-gallon bucket on the food carts for every meal for nurse aides to scrape the leftover food from residents' plates and trays into them. The nurse aides will then wheel the food cart with bucket to the front of the hallways and kitchen staff will come and wheel the uncovered buckets through the facility to the kitchen. The plates should not be scraped into buckets in the hallways and lounge areas; however, that is the direction given from administration. Interview with Assistant Director of Nursing and Infection Preventionist on August 14, 2024, at 2:15 p.m. confirmed that scraping the leftover food into five-gallon buckets on the carts that sit in the hallways during and after meals with the uncovered buckets full of old food is not homelike. 28 Pa. Code 207.2(a) Administrator's Responsibility.

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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 0623 Level of Harm - Minimal harm or potential for actual 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41233 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to notify the resident and resident representative in writing regarding the reason for transfer to hospital, and failed to notify the ombudsman for the hospitalization s for five of 32 residents reviewed (Residents 4, 7, 14, 41, 69). Findings include: The facility's policy for Admission, Transfer and Discharge Notification, dated December 1, 2024, indicated that upon transfer to the hospital the resident and resident representative will be notified in writing, and the ombudsman will be notified. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated May 27, 2024, indicated that the resident was cognitively intact, required assistance with care needs, required supplemental oxygen and had diagnoses that included congestive heart failure (the heart cannot pump blood well enough to meet the body's needs), chronic respiratory failure (blood does not have enough oxygen and causes difficulty breathing), and chronic obstructive pulmonary disease (chronic lung disease making breathing difficult). A nursing note for Resident 4, dated May 15, 2024, indicated that the resident was lethargic and did not feel well, stating that her heart felt funny. The Medical Director was notified, and the resident was sent to the hospital. She was admitted with pulmonary edema (fluid in the lungs) and hypercarbia (too much carbon dioxide in the blood). Review of Resident 4's clinical record revealed no documented evidence that the resident representative was notified in writing of the purpose for the resident's transfer, and no evidence that the ombudsman was notified of the May 15, 2024, hospitalization . An annual MDS assessment for Resident 7, dated June 1, 2024, indicated that the resident was cognitively impaired, required assistance from staff for her daily care needs, and had diagnoses that included hypertension and kidney failure. A nursing note, dated June 21, 2024, for Resident 7 indicated that the resident was unresponsive, and she was transferred to the emergency department. Review of Resident 7's clinical record revealed no documented evidence that the resident representative was notified in writing of the purpose for resident's transfer, and no evidence that the ombudsman was notified of the June 21, 2024, hospitalization . A quarterly MDS assessment for Resident 14, dated July 24, 2024, indicated that the resident was cognitively impaired, required assistance from staff for her daily care needs, and had diagnoses that included cerebral palsy (a group of neurological disorders that affect a person's ability to move, balance, and maintain posture). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note, dated May 25, 2024, for Resident 14 indicated that the resident was unresponsive and was transferred to the emergency department. Review of Resident 14's clinical record revealed no documented evidence that the resident representative was notified in writing of the purpose for resident's transfer, and no evidence that the ombudsman was notified of the hospitalization on [DATE]. A quarterly MDS assessment for Resident 41, dated June 7, 2024, indicated that the resident was severely cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included high blood pressure, dementia and stroke. A nursing note, dated May 21, 2024, for Resident 41 indicated that the resident sustained a laceration to her head and was transferred and admitted to the hospital. Review of Resident 41's clinical record revealed no documented evidence that the resident representative was notified in writing of the purpose for resident's transfer, and no evidence that the ombudsman was notified of the hospitalization on [DATE]. An admission MDS assessment for Resident 69, dated May 16, 2024, indicated that the resident was cognitively intact, required maximum assistance from staff for daily care needs, and had diagnoses that included benign prostatic hyperplasia (BPH, a medical condition that causes an enlarged prostate). A nursing note, dated May 17, 2024, for Resident 69 indicated that the resident was experiencing abdominal pain, and the bladder scan showed urinary retention. The medical doctor was notified and new orders were received to send the resident to the emergency department for evaluation. Review of Resident 69's clinical record revealed no documented evidence that the resident representative was notified in writing of the purpose for the resident's transfer, and no evidence that the ombudsman was notified regarding the hospitalization on [DATE]. Interview with the Director of Nursing on August 15, 2024, at 1:09 p.m. confirmed that there was no documented evidence in the clinical records of Residents 4, 7, 14, 49 and 69 that the resident representatives were notified in writing of the purpose for the transfers and no evidence that the ombudsmen were notified of the hospitalization s. 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(f)(g) Resident Rights.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 41233 Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a significant change Minimum Data Set assessment was completed for one of 32 residents reviewed (Resident 38). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that a significant change MDS assessment (significant change - a major decline or improvement in a resident's status that meets specific criteria, including the initiation of hospice) was to be completed no later than 14 days from the date the significant change was identified. Physician's orders, dated July 8, 2024, for Resident 38 indicated that the resident was ordered hospice services related to a terminal prognosis of heart failure. There was no documented evidence that the facility completed a significant change MDS assessment after Resident 38 was placed on hospice services. Interview with the Director of Nursing and the Director of Case Management on August 15, 2024, at 2:00 p. m. confirmed that a significant change MDS assessment was not completed for Resident 38 and should have been. 28 Pa. Code 211.5(f) Clinical Records.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 41233 Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate comprehensive Minimum Data Set assessments for two of 32 residents reviewed (Residents 41, 59). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that Section P0200E was to be coded to capture the use of wander/elopement alarms. The section was to be coded zero (0) for not used, one (1) for used less than daily, or two (2) for used daily. Physician's orders for Resident 41, dated May 23, 2024, included orders for the resident to use a wanderguard alarm. Review of Resident 41's Treatment Administration Records (TAR) for June 2024 indicated that the resident used a wanderguard alarm for the entire month of June 2024. A quarterly MDS assessment for Resident 41, dated June 7, 2024, revealed that Section P0200E was coded with a zero (0), indicating that the resident did not use a wanderguard alarm. Physician's orders for Resident 59, dated July 14, 2024, included orders for the resident to use a wanderguard alarm. Review of Resident 59's TAR for July 2024 indicated that the resident used a wanderguard alarm during the assessment period. An admission MDS assessment for Resident 59, dated July 17, 2024, revealed that Section P0200E was coded with a zero (0), indicating that the resident did not use a wanderguard alarm during the look-back period. The RAI Manual, dated October 2023, indicated that Section E0900 was to be coded to capture wandering presence and frequency. The section was to be coded zero (0) indicating that wandering behavior was not exhibited, one (1) indicating behavior occurred 1-3 days, two (2) indicating behavior occurred 4-6 days or three (3) indicating behavior occurred daily. A nursing note for Resident 59, dated July 14, 2024, indicated that the resident was observed outside in the parking lot by a visitor and brought back into the building by activity staff. The resident was instructed that he is not to go outside without family or staff. The Medical Director and family were notified, and a wanderguard bracelet was applied to his left ankle. Review of clinical records for Resident 59 revealed no further instances of wandering behaviors. An admission MDS assessment for Resident 59, dated July 17, 2024, revealed that Section E0900 was coded zero (0) indicating that wandering behavior was not exhibited during the look-back period. Interview with the Director of Case Management (a registered nurse who is responsible for overseeing the completion and accuracy of MDS assessments) on August 14, 2024, at 1:57 p.m. confirmed that the above MDS assessments for Residents 41 and 59 were not accurate. 28 Pa. Code 211.5(f) Clinical Records.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43856 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for three of 32 residents reviewed (Resident's 15, 59, 285). Findings: A facility policy, dated December 1, 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. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 15, dated July 29, 2024, revealed that the resident was cognitively intact, required assistance from staff for her daily care needs, and had diagnoses that included a right below-the-knee amputation and diabetes. Observations of Resident 15 on August 12, 2024, at 12:30 p.m. revealed that the resident had a prosthetic leg in her room that she used daily due to the amputation of her right leg below the knee. There was no documented evidence that a care plan was developed to address Resident 15's individual care and treatment needs related to the use of a prosthetic leg. Interview with the Assistant Director of Nursing on August 14, 2024, at 10:35 a.m. confirmed that a care plan to address the care needs related to Resident 15's use of a prosthetic leg was not developed and should have been. An admission MDS assessment for Resident 59, dated July 17, 2024, indicated that the resident was cognitively intact, required assistance with care needs including toileting and hygiene, was frequently incontinent of urine, and occasionally incontinent of bowel. Review of Resident 59's toileting, hygiene, and bowel and bladder records indicated that the resident had episodes of incontinence of bowel and bladder through the months of July and August 2024 and required assistance with toileting hygiene. There was no documented evidence that a care plan was developed to address Resident 59's incontinence or his need for assistance with toileting hygiene. Interview with the Assistant director of Nursing on August 14, 2024, at 2:04 p.m. confirmed that a care plan to address the care needs related to Resident 59's incontinence and need for assistance with toileting hygiene was not developed and should have been. Review of the clinical record revealed that Resident 285 was admitted on [DATE], and had diagnoses that included the presence of a cardiac pacemaker (a small battery-powered device implanted in the body to monitor the heart's rhythm and rate). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician's orders for Resident 285, dated August 10, 2024, included an order for the resident to receive 5 milligrams (mg) of Apixaban (anticoagulant) twice daily. Physician's orders for Resident 285, dated August 11, 2024, included an order for the resident to receive 75 mg of Clopidogrel Bisulfate (antiplatelet medication) once daily. There was no documented evidence that a care plan was developed to address Resident 285's individual care and treatment needs related to her use of anticoagulant and antiplatelet medication. Interview with the Assistant Director of Nursing on August 14, 2024, at 1:43 p.m. confirmed that a care plan to address the care needs related to Resident 285's anticoagulant and antiplatelet medication use was not developed and should have been. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41233 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that care plans were updated/revised to reflect changes in care needs for five of 32 residents reviewed (Residents 4, 29, 38, 41, 63). Findings include: The facility's policy regarding care plans, dated December 1, 2023, included that care plans were to be revised as changes in the resident's condition dictated and should reflect the professional services that were responsible for each element of care. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated May 27, 2024, indicated that the resident was cognitively intact, required assistance with care needs, required supplemental oxygen, and had diagnoses that included congestive heart failure (the heart cannot pump blood as well as it should causing weight gain due to fluid to build up in the lungs and lower legs), chronic respiratory failure (blood does not have enough oxygen and causes difficulty breathing), and chronic obstructive pulmonary disease (chronic lung disease making breathing difficult). Physician's orders for Resident 4, dated May 21, 2024, included an order for a 2,000 cubic centimeter (cc) fluid restriction per day. She was to receive 1440 cc of fluids from dietary, 480 cc of fluids from nursing, and 80 cc at nursing discretion. There was no documented evidence that Resident 4's care plan was revised to reflect her need for fluid restriction. Interview with the Director of Nursing on August 15, 2024, at 2:07 p.m. confirmed that Resident 4's care plan was not revised to reflect the need for fluid restriction and it should have been. A quarterly MDS assessment for Resident 29, dated May 15, 2024, indicated that the resident was severely cognitively impaired, required assistance with daily care needs, and had diagnoses that included dementia with Lewy bodies (a progressive neurogenic disorder that leads to a decline in thinking, reasoning, memory and often includes sleep disturbances). A nursing note, for Resident 29, dated December 29, 2023, at 3:04 a.m., indicated that the resident expressed that she was tired and wanted to go to bed, walked to her room, and ten minutes later the door alarms went off. Staff went to see what was going on and deactivated the alarm to find out that she was outside wondering around the fenced-in area. There was no documented evidence that Resident 29's care plan was revised to reflect interventions to prevent further elopements. Interview with the Director of Nursing on August 15, 2024, at 1:14 p.m. confirmed that Resident 29's care plan was not revised to reflect interventions to prevent the resident from additional elopements, and it should have been. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS assessment for Resident 38, dated May 31, 2024, indicated that the resident was cognitively intact and had diagnoses that included hospice and atrial fibrillation (an irregular rapid heart beat). Physician's orders for Resident 38, dated September 7, 2023, included an order for the resident to receive 150 milligrams (mg) of Pradaxa (a blood thinner) twice a day, and physician's orders for Resident 38, dated September 14, 2023, included an order to discontinue the Pradaxa. There was no documented evidence that Resident 38's care plan was updated to reflect the discontinuation of Pradaxa. Interview with Licensed Practical Nurse 3 on August 13, 2024, at 3:29 p.m. confirmed that Resident 38 no longer received Pradaxa and that it should not be on his current care plan. Interview with the Assistant Director of Nursing on August 13, 2024, at 3:57 p.m. confirmed that Resident 38's care plan should have been updated to reflect the discontinuation of Pradaxa, and it was not. A quarterly MDS assessment for Resident 41, dated June 7, 2024, indicated that the resident was severely cognitively impaired and had diagnoses that included dementia with behavioral disturbances and a history of elopement (leaving the facility due to confusion or memory loss). Physician's orders for Resident 41, dated May 23, 2024, included an order for the resident to wear a wanderguard (a bracelet worn on the wrist or ankle to monitor a resident's whereabouts for safety purposes) There was no documented evidence that Resident 41's care plan was updated to reflect the use of a wanderguard. Interview with the Assistant Director of Nursing on August 14 2024, at 2:45 p.m. confirmed that Resident 41's care plan should have been updated to reflect the implementation of a wanderguard, and it was not. An admission MDS assessment for Resident 63, dated June 2, 2024, indicated that the resident was cognitively impaired, required assistance with care needs, had behaviors not affecting others, and had diagnoses that included Alzheimer's disease, dementia and depression. A review of the clinical record for Resident 63 revealed that she had episodes of sobbing since June 18, 2024. A care plan for psychotropic medication, dated May 28, 2024, indicated that the resident received antidepressant medication. Physician's orders for Resident 63, dated July 16, 2024, included an order for the resident to receive 0.5 mg of Ativan twice daily for 30 days as needed for sobbing. Physician's orders for Resident 63, dated August 13, 2024, included an order for the resident to receive 0.5 mg of Ativan twice daily for 30 days as needed for anxiety. There was no documented evidence in the clinical record to indicate that Resident 63's care plan was revised to include the use of antianxiety medication or her episodes of sobbing. Interview with the Director of Nursing on August 15, 2024, at 2:03 p.m. confirmed that Resident 63's care plan was not revised to reflect her need for antianxiety medications and confirmed that her care plan was not revised to reflect her sobbing. (continued on next page)

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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** 48941 Based on clinical record reviews, staff interviews, and observations, it was determined that the facility failed to clarify and/or obtain physician's orders for three of 32 residents reviewed (Residents 11, 59, 81). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 11, dated July 5, 2024, indicated that the resident was cognitively impaired, required assistance with care needs, and had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications to a person who is unable to eat or drink by mouth). Review of Resident 11's clinical record revealed special instructions that indicated she was to receive her medications through her feeding tube. Current physician's orders for Resident 11 included orders for the resident to receive two 325 milligrams (mg) tablets of Acetaminophen by mouth every four hours as needed for pain or fever, two 8.6 mg tablets of Senna (a laxative) by mouth at bedtime, 4 mg of Ondansetron HCl (a medication used to treat nausea) by mouth every eight hours as needed for nausea/vomiting, and 2.5 mg of Warfarin sodium (a medication used to thin the blood) by mouth at bedtime. Interview with the Assistant Director of Nursing on August 14, 2024, at 8:55 a.m. confirmed that the medications for Resident 11 listed above should have been clarified to reflect that the resident was to receive the medications by way of the feeding tube. An admission MDS assessment for Resident 59, dated July 17, 2024, indicated that the resident was cognitively intact, required assistance with care needs, and had a feeding tube. A care plan for the resident's feeding tube, dated July 11, 2024, indicated that the resident was to receive medications and flushes as ordered. Current physician's orders for Resident 59, included orders for the resident's feeding tube placement to be checked prior to medications and flushes, for the resident to receive two 325 mg tablets of Acetaminophen by mouth every four hours as needed for pain or fever, 4 mg of Ondansetron HCl (a medication used to treat nausea) by mouth every eight hours as needed for nausea/vomiting, 30 milliliters (ml) of Milk of Magnesia (a laxative) by mouth by every 72 hours as needed for constipation for no bowel movement by the morning of the third day and 30 ml by mouth every 24 hours as needed for constipation, 50 mg of Trazadone (an antidepressant used to aid sleep) by mouth at bedtime, 5 mg of Escitalopram Oxalate (a medication used to treat depression) by mouth daily, and 81 mg of Aspirin by mouth daily. Interview with the Assistant Director of Nursing on August 13, 2024, at 1:21 p.m. confirmed that the medications for Resident 59 listed above should have been clarified to reflect that the resident was to receive the medications by way of the feeding tube. Resident 81 was admitted to the facility on [DATE], with a diagnosis of quadriplegia (paralysis of both arms and legs) due to a ground-level fall at home resulting in a neck fracture. (continued on next page)

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	395552	A. Building B. Wing	08/15/2024

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations during an interview with Resident 81 on August 13, 2024, at 12:34 p.m. revealed bilateral PRAFO boots (device that floats the heel and maintains the ankle in a neutral 90 degree position to help prevent foot drop, pressure ulcers and contractures) lying on a chair in the corner of his room. The resident indicated that they were custom made boots from the hospital that are to be worn to prevent foot drop (a symptom of weakness or paralysis of the muscles that lift the foot). Interview with the Therapy Manager on August 13, 2024, at 3:51 p.m. revealed that Resident 81 did have Pressure Relief Ankle Foot Orthosis (PRAFO) (custom-fitted AFO that can help manage ankle/foot abnormalities or injuries)in his room and indicated they would have needed to be ordered from the hospital on discharge for therapy to have looked at them. Discharge orders from the hospital for Resident 81, dated August 6, 2024, revealed that the resident was to wear bilateral PRAFO two hours on and two hours off. There was no documented evidence that staff notified the physician and clarified if there should have been an admission order for Resident 81 to wear the bilateral PRAFO's. Observations during an interview with Resident 81 on August 13, 2024, at 12:34 p.m. revealed that the resident was wearing a left hand/wrist splint that the resident indicated was used to stabilize his hand so he could use the controls on his motorized chair. Review of therapy notes for Resident 81, dated August 8, 2024, revealed that the resident was ordered a new left wrist cock-up splint to use with wheelchair mobility. Interview with the Therapy Manager on August 13, 2024, at 3:51 p.m. revealed that Resident 81 was wearing a left wrist cock-up splint to stabilize his hand so he could use the control to his motorized chair. There was no documented evidence in the resident's clinical record that the splint was ordered. Interview with the Director of Nursing on August 13, 2024, at 3:15 p.m. confirmed that Resident 81's orders for the PRAFO's were missed on the resident's discharge orders and should have been ordered at the time of admission and confirmed that there were no orders in place for Resident 81's left wrist cock-up splint. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41233 Based on clinical record reviews and staff interviews, it was determined that the facility failed to perform a physical assessment after an elopement for one of 32 residents reviewed (Resident 29). Findings include: The facility's policy regarding elopements and wandering residents, dated December 1, 2024, revealed that when a resident elopes (leaves the premises without authorization), a registered nurse will perform a physical assessment upon return and document and report the findings to the physician. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 29, dated May 15, 2024, indicated that the resident was severely cognitively impaired, required assistance with daily care needs, and had diagnoses that included dementia with Lewy bodies (a progressive neurogenic disorder that leads to a decline in thinking, reasoning, memory and often includes sleep disturbances). A nursing note for Resident 29, dated December 29, 2023, at 3:04 a.m., indicated that the resident expressed that she was tired and wanted to go to bed. She walked to her room and ten minutes later the door alarms went off. Staff went to see what was going on and deactivated the alarm to find out that she was outside wondering around the fenced-in area. There was no documented evidence that following her elopement a physical assessment was done by a registered nurse, with documentation of findings sent to the physician. Interview with the Director of Nursing on August 15, 2024, at 1:12 p.m. confirmed that staff did not complete a physical assessment after Resident 29 eloped from the facility on December 29, 2024, and they should have. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 48941 Based on review of facility policies and clinical record, as well as staff interviews, it was determined that the facility failed to ensure that fluid restrictions were being followed and documented per physician's orders and failed to ensure that a resident's weight was obtained and documented as per physician's order for one of 32 residents reviewed (Resident 4). Findings include: A facility policy regarding fluid restriction, dated December 1, 2023, indicated that the nurse will obtain and verify the physician's order for the fluid restriction, which will include the breakdown of the amount of fluid per 24 hours to be distributed between food, nutrition, and nursing departments, and will be recorded on the medication record or other format as per facility protocol. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated May 27, 2024, indicated that the resident was cognitively intact, required assistance with care needs, required supplemental oxygen, and had diagnoses that included congestive heart failure (the heart cannot pump blood as well as it should, causing weight gain due to fluid to build up in the lungs and lower legs), chronic respiratory failure (blood does not have enough oxygen and causes difficulty breathing), and chronic obstructive pulmonary disease (chronic lung disease making breathing difficult). Physician's orders for Resident 4, dated May 21, 2024, included an order for the resident to be on a 2,000 Cubic centimeter (cc) fluid restriction per day. She was to receive 1440 cc of fluids from dietary, 480 cc of fluids from nursing, and 80 cc at nursing discretion. A review of Resident 4's Medication Administration Record (MAR) for May, June, July and August 2024 and a review of clinical records revealed no documented evidence that the resident's fluid restriction was being documented and followed as per physician's orders. Physician's orders for Resident 4, dated June 20, 2024, indicated that the resident was ordered to be weighed every other day in the morning and documented. A review of Resident 4's Treatment Administration Record (MAR) for June, July and August 2024 and review of clinical records revealed that weights were not obtained as ordered on June 21, 25, 29, 2024; July 19, 2024; and August 2 and 6, 2024. An interview with the Director of Nursing on August 15, 2024, at 2:07 p.m. confirmed that there was no documented evidence that Resident 4's fluid restriction was being followed and documented as per physician's orders, and no documented evidence that weights were obtained and documented as ordered on the dates listed above. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48941 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to obtain physician's orders for the care and services related to tube feedings for one of 32 residents reviewed (Resident 81). Findings include: A facility's policy regarding gastrostomy feeding, dated December 1, 2023, indicated that placement of the gastrostomy tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications to a person who is unable to eat or drink by mouth) will be done by placing a stethoscope to the stomach and injecting 10 cubic centimeters (cc) of air. A facility policy regarding gastric tube care, dated December 1, 2023, indicated that gastric tube care was to be done to prevent irritation and skin breakdown, prevent odor and prevent discomfort, and was to be documented in the Treatment Administration Record (TAR). Resident 81 was admitted to the facility on [DATE], with a diagnosis of quadriplegia (paralysis of both arms and legs) due to a ground-level fall at home resulting in a neck fracture. A provider note for Resident 81, dated August 7, 2024, indicated the resident had a feeding tube. Special instructions noted in the resident's clinical record revealed that the resident was NPO (nothing by mouth) status and was to receive his medications by way of his gastrostomy tube. Current physician's orders for Resident 81, dated August 8, 2024, included orders for the resident's feeding tube to be flushed with 250 cc's of water every four hours, six times a day for hydration, and for the resident to receive 250 milliliters (ml) of two calorie HN Enteral Feed (high calorie, high protein nutritional supplement) by way of bolus (method for delivering nutrition through a feeding tube using a syringe) administration four times daily after meals and at bedtime. Review of Resident 81's clinical record revealed no documented evidence that orders were obtained for NPO status; to verify placement of the feeding tube prior to administration of feedings, flushes and medications; to flush the feeding tube between and after medication administration; or to address the resident's need for tube feeding care. Observations on August 13, 2024, at 12:30 p.m. revealed that Resident 81 was receiving his tube feeding by way of a feeding pump at the rate of 250 ml per hour. Interview with the resident at this time revealed that he sometimes gets his feedings bolus and sometimes get his feedings by way of the pump. Interview with Licensed Practical Nurse 4 on August 13, 2024, at 12:25 p.m. revealed that at times Resident 81 requests his tube feedings be given by way of the pump because the resident states his stomach gets too full when it is given bolus. She stated that the pump is set to deliver the tube feeding at 250 ml per hour. She stated they administer the flushes the same at times depending on the resident's preference. There is no documented evidence that orders were obtained for Resident 81 to receive his bolus tube feedings by way of the feeding pump. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Assistant Director of Nursing on August 13, 2024, at 2:26 p.m. confirmed that the resident did not have an order to reflect Resident 81's NPO status; did not have an order to check the feeding tube for placement prior to administering tube feedings, flushes and medication administration; did not have an order for feeding tube care; and did not have an order to administer bolus tube feedings and water flushes for hydration via the tube feeding pump. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48941 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from unnecessary psychotropic medications by failing to ensure that non-pharmacological (non-medication) behavioral interventions (individualized, non-pharmacological approaches to care) were attempted prior to the administration of as needed antianxiety medications for one of 32 residents reviewed (Residents 63). Findings include: The facility's policy regarding psychotropic medications (any medication that affects brain activities associated with mental processes and behavior), dated December 1, 2023, indicated that residents who use psychotropic drugs shall receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs. Non-pharmacological interventions that have been attempted, and the target symptoms for monitoring, shall be included in the documentation. As needed orders for all for all psychotropic medications shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 63, dated June 2, 2024, indicated that the resident was cognitively impaired, required assistance with care needs, had behaviors not affecting others, and had diagnoses that included Alzheimer's disease, dementia and depression. Physician's orders for Resident 63, dated June 25, 2024, included an order for the resident to receive 0.5 milligrams (mg) of Ativan every 24 hours as needed for sobbing. Physician's orders for Resident 63, dated July 3, 2024, included an order for the resident to receive 0.5 mg of Ativan daily as needed for sobbing. Physician's orders for Resident 63, dated July 9, 2024, included an order for the resident to receive 0.5 mg of Ativan twice daily as needed for sobbing. Physician's orders for Resident 63, dated July 16, 2024, included an order for the resident to receive 0.5 mg of Ativan twice daily for 30 days as needed for sobbing. Physician's orders for Resident 63, dated August 13, 2024, included an order for the resident to receive 0.5 mg of Ativan twice daily for 30 days as needed for anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) for Resident 63 for June, July and August 2024 revealed that the resident was administered 0.5 mg of Ativan on the following dates and times: June 26 at 11:57 a.m., June 27 at 5:26 p.m., June 28 at 7:19 p.m., June 29 at 8:00 p.m., June 30 at 8:20 p.m., July 2 at 7:01 p.m., July 4 at 4:55 p.m., July 5 at 7:15 p.m., July 8 at 8:00 p.m., July 9 at 11:30 a.m. and 7:24 p.m., July 10 at 8:31 a.m. and 4:57 p.m., July 11 at 7:33 a.m. and 7:06 p.m., July 12 at 6:30 p.m. and 10:29 p.m., July 14 at 2:58 p.m., July 16 at 8:41 a.m. and 7:34 p.m., July 17 at 7:27 a.m. and 6:25 p.m., July 19 at 4:37 p.m., July 20 at 8:04 a.m. and 6:05 p.m., July 21 at 11:00 a.m. and 7:00 p.m., July 22 at 4:08 p.m., July 23 at 7:39 p.m., July 25 at 10:49 a.m. and 4:59 p.m., July 26 at 10:03 a.m. and 7:47 p.m., July 27 at 12:54 p.m., July 28 at 1:10 p.m., July 29 at 7:46 p.m., July 30 at 1:00 p.m. and 5:58 p.m., July 31 at 8:00 a.m. and 7:00 p.m., August 1 at 6:35 p.m. and 11:19 p.m., August 3 at 9:44 a.m., August 6 at 7:40 a.m., August 7 at 12:00 p.m., August 8 at 9:00 a.m., August 9 at 9:15 a.m. and 7:08 p.m., August 10 at 9:00 p.m., and August 12 at 9:11 a.m. There was no documented evidence that non-pharmacological behavioral interventions were attempted prior to administering Ativan on these dates and times. Interview with the Assistant Director of Nursing on August 15, 2024, at 1:18 p.m. confirmed that non-pharmacological interventions should have been attempted prior to the administration of Ativan to Resident 63 on the above dates and times. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48809 Based on review of physican's orders, as well as observations and staff interviews, it was determined that the facility failed to ensure that the facility's emergency controlled medications (narcotics) were properly secured in one of one medication rooms reviewed. Findings include: The facility's policy regarding the storage of medications, dated December 1, 2023, indicated that narcotic medications were to be stored behind a double lock and secured in a narcotics box in the refrigerator. Observations on August 12, 2024, at 1:55 p.m. revealed that the facility's emergency narcotic medications were stored in the medication room inside an unsecured refrigerator and could easily be removed from the medication room. Interview with Registered Nurse 2 on August 12, 2024, at 2:00 p.m. confirmed that the refrigerator containing the narcotic box was not secured to the refrigerator and that the narcotic box contained narcotics. Interview with the Assistant Director of Nursing on August 14, 2024, at 12:53 p.m. confirmed that the emergency narcotic medications should have been secured in the refrigerator and were not. 28 Pa. Code 211.9(a)(1) Pharmacy Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48809 Based on review of facility policies, resident interviews, 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 food safety requirements, dated December 1, 2023, revealed that foods and beverages shall be distributed and served in a manner to prevent contamination, and food shall be maintained at a proper temperature and out of the danger zone. Observations on the 300 hall on August 12, 2024, at 11:15 p.m. revealed a cart with an opened half-gallon container of white milk, chocolate milk, cranberry juice, orange juice, and iced tea, as well as opened cans of soda that were not in cold containers. Observations on the 300 hall on August 14, 2024, at 12:11 p.m. revealed a cart with iced tea without a lid on it being stored on top of the cart and not in a cold container. There were also half-gallon containers of milk, juice, and iced tea being stored on top of cart both inside and outside of the cold containers. The milk container and several other containers were warm to the touch. Interview with Nutritional Aide 5 on August 14, 2024, at 1:12 p.m. revealed that the liquids being stored on the cart were going to be placed back into the refrigerator to be served at the next meal. Interview with the Director of Nutritional Services on August 14, 2024, at 1:17 p.m. revealed that the temperature of the chocolate milk was 60.0 degrees Fahrenheit and the cranberry juice was 57.9 degrees Fahrenheit and confirmed that these drinks were available to be served to residents at those temperatures and should not have been.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48809 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to store and prepare food in accordance with professional standards for food service safety. Findings include: The facility's policy regarding food labeling and dating, dated December 1, 2023, revealed that all foods stored in the refrigerator or freezer will be covered, labeled, and dated. Observations of the walk-in refrigerator on August 12, 2024, at 8:55 a.m. revealed an opened and undated container of cherries, three storage containers, one tray of peas, two pans of chicken, and one tray of breadsticks in a cart that were not dated. Observations of the walk-in freezer on August 12, 2024, at 9:10 a.m. revealed a half bag of onion rings, a half bag of french fries, and a bag containing three pitas that were opened and not dated or labeled. Interview with the Dietary Manager on August 12, 2024, at 9:13 a.m. confirmed that that the food items mentioned above should have been labeled and/or dated but were not. 28 Pa. Code 211.6(f) Dietary Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 48809 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending September 21, 2023, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending August 14, 2024, identified repeated deficiencies related to accurate Minimum Data Set assessments, comprehensive and individualized care plans, professional standards, quality of care, tube feeding management, and food procurement. The facility's plan of correction for a deficiency regarding completing accurate MDS assessments, cited during the survey ending September 21, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding accurate MDS assessments. The facility's plan of correction for a deficiency regarding developing and implementing comprehensive individualized care plans, cited during the survey ending September 21, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding developing and implementing comprehensive individualized care plans for each resident. The facility's plan of correction for a deficiency regarding services meeting professional standards, cited during the survey ending September 21, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F658, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding professional standards. The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending September 21, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care. (continued on next page)

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	08/15/2024

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's plan of correction for a deficiency regarding tube feeding management, cited during the survey ending September 21, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F693, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding tube feeding management. The facility's plan of correction for a deficiency regarding proper food procurement, cited during the survey ending September 21, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F812, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding food procurement. Refer to F641, F656, F658, F684, F693, F812. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.