

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/23/2024
NAME OF PROVIDER OR SUPPLIER  Premier Washington Rehabilitation and Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 36 Old Hickory Ridge Rd Washington, PA 15301	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>31343</p> <p>Based on observation, clinical record review, observation, resident and staff interview, it was determined that the facility failed to respect residents' rights in the handling and protection of their personal property and clothing for eleven of thirteen residents interviewed (Residents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, and R11).</p> <p>Findings include:</p> <p>During an observation on 7/23/24, at 10:50 a.m., of the facility soiled and clean laundry areas, there were two staff working. There was three heaping piles of soiled personal items on carts in the soiled laundry area and two heaping carts and six covered laundry carts with personal laundry in the clean laundry area.</p> <p>The Nursing Home Reform Act established the following rights for nursing home residents:</p> <ul style="list-style-type: none"> <li>-The right to freedom from abuse, mistreatment, and neglect;</li> <li>-The right to freedom from physical restraints;</li> <li>-The right to privacy;</li> <li>-The right to accommodation of medical, physical, psychological, and social needs;</li> <li>-The right to participate in resident and family groups;</li> <li>-The right to be treated with dignity;</li> <li>-The right to exercise self-determination;</li> <li>-The right to communicate freely;</li> <li>-The right to participate in the review of one's care plan, and to be fully informed in advance about any changes in care, treatment, or change of status in the facility; and</li> <li>-The right to voice grievances without discrimination or reprisal.</li> </ul> <p>(continued on next page)</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/23/24, at 11:15 a.m., the Laundry Housekeeping Manager Employee E1 stated that the afternoon shift staff person refuses to deliver personal items, she has been written up several times but I can't get rid of her or I will have no one on afternoon shift.</p> <p>During an interview 7/23/24, at 11:30 a.m., the Director of Nursing (DON) was made aware of the laundry not being delivered and the observation and interview completed confirming the fact that the facility staff is not delivering personal clothing. The DON confirmed that the facility failed to respect residents' rights in the handling and protection of their personal property and clothing.</p> <p>28 Pa Code 201.18(e)(1)(h) Management</p> <p>28 Pa Code 201.29 (a)(c)(j)(k) Resident rights</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31343</p> <p>Based on resident and staff observations, and staff interviews, it was determined that the facility failed to have sufficient dietary staff to perform essential kitchen duties in the Main Kitchen.</p> <p>Findings include:</p> <p>The facility Meal Delivery policy dated 2/28/24, indicated that delivery times for Food Truck delivery have a ten-minute allowance and if later than that, have to have an explanation identified, this was indicated as the Action Plan.</p> <p>During an interview on 7/23/24, at 8:35 a.m., Staff Employee E2 stated that food trucks are never on time, residents never get what they ask for and I have had to call down for correct tray; this last weekend the trays were two and three hours late for dinner, residents got meals at 8:00 at night.</p> <p>During an interview on 7/23/24, at 9:04 a.m., Resident R5 stated that the trays are never on time; food is cold, especially at breakfast; there are no hot plates under plates; the food taste is sometimes not good; and this past weekend we didn't get our dinner til almost 9:00 p.m.</p> <p>During an interview on 7/23/24, at 9:09 a.m., Resident Resident R7 stated trays are always late, especially this past weekend, actually over the past couple months; there are never condiments; I had to go buy my own sugar and salt; the trays have missing items or they just give you whatever they want.</p> <p>During an observation on 7/23/24, at 9:18 a.m., of the trays on the breakfast cart of the 3 East Nursing Unit, did not include hot plates underneath the plates on the cart.</p> <p>During an interview on 7/23/24, at 9:26 a.m., the Food Service Director Employee E3 stated that she was aware of the past weekend trays being late and that she could not work every day, twelve hours a day; it's hard when you don't have any staff to run a kitchen; the hotplate warmers sometimes work and sometimes don't; staff just don't work together; how do you make them, they have to learn.</p> <p>During an observation on 7/23/24, the lunch delivery identified on the [NAME] Meal Delivery Log indicated the at the lunch cart delivery service on the 2 East Nursing unit cart delivery was to be at 12:08 p.m., and 12:15 p.m., staff stated that they only get one cart. The cart did not arrive until 12:30 p.m., fifteen minutes after the posted arrival time.</p> <p>Review of Dietary Council Meeting Minutes from 5/3/24, through 7/19/24, identified dietary issues of late food, cold food and taste of food issues that have been ongoing.</p> <p>Review of the Grievance logs dated May 2024, through July 2024, identified complaints related to food quality, and not receiving what was ordered.</p> <p>During an interview on 7/23/24, at 9:26 a.m., the Food Service Director confirmed that the facility failed to have sufficient dietary staff.</p> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>28 Pa. Code: 211.6 (c) Dietary services.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31343</p> <p>Based on observations, review of facility menu, resident interviews, and staff interviews it was determined that the facility failed to follow the displayed menu for one of three observed meals (lunch meal 7/23/24), and failed to provide residents with their preferred dietary choices for three of three residents identified (Residents R100, R101, R102).</p> <p>Findings include:</p> <p>During an observation on 7/23/24, the posted menu on the 3 East and 3 South Nursing Units was identified as [NAME] Spring Summer 2024 week 4 menu.</p> <p>During an interview on 7/23/24, at 8:35 a.m., Staff Employee E2 stated that food trucks are never on time; residents never get what they ask for and I have had to call down for correct tray; this last weekend the trays were two and three hours late for dinner, residents got meals at 8:00 at night; the food served today was not what is on that menu.</p> <p>During an interview on 7/23/24, at 9:09 a.m., Resident Resident R7 stated trays are always late, especially this past weekend, actually over the past couple months; there are never condiments, I had to go buy my own sugar and salt; the trays have missing items or they just give you whatever they want.</p> <p>During an interview on 7/23/24, at 9:26 a.m., the Diet Clerk Employee E4, confirmed that the posted menu was not the menu currently being used that the facility was in week 1 and that she would take care of that.</p> <p>During an observation on 7/23/24, from 11:30 a.m., through 11:48 a.m., the following was observed:</p> <p>Food was on hot carts on either side of trayline with temperatures of food being assessed by the Food Service Director at 11:30 a.m.</p> <p>Trays began being plated with 3 South residents. When ticket and food on each tray of the three of three observed were identified, each tray had requested items that had not been placed on each tray.</p> <p>During an interview on 7/23/24, at 11:32 a.m., the Food Service Director Employee E3 confirmed that the trays did not have all of the requested/desired foods on them the facility failed to follow the displayed menu for one of three observed meals (lunch meal 7/23/24), and failed to provide residents with their preferred dietary choices for Resident R100, R101 and R102.</p> <p>Pa Code: 211.6(a) Dietary services.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31343</p> <p>Based on review of facility documents, meal delivery observations, resident interviews, and staff interviews it was determined that the facility failed to ensure that meals were served at regularly scheduled times for three of three days identified (7/20/24, 7/21/24 and 7/23/24).</p> <p>Findings include:</p> <p>The facility Meal Delivery policy dated 2/28/24, indicated that delivery times for Food Truck delivery have a ten-minute allowance and if later than that, have to have an explanation identified, this was indicated as the Action Plan.</p> <p>During an interview on 7/23/24, at 8:35 a.m., Staff Employee E2 stated that food trucks are never on time; residents never get what they ask for and I have had to call down for correct tray; this last weekend the trays were two and three hours late for dinner, residents got meals at 8:00 at night.</p> <p>During an interview on 7/23/24, at 9:04 a.m., Resident R5 stated that the trays are never on time; food is cold, especially at breakfast; there are no hot plates under plates; the food taste is sometimes not good; this past weekend we didn't get our dinner til almost 9:00 p.m.</p> <p>During an interview on 7/23/24, at 9:09 a.m., Resident Resident R7 stated trays are always late, especially this past weekend, actually over the past couple months; there are never condiments, I had to go buy my own sugar and salt;the trays have missing items or they just give you whatever they want.</p> <p>During an interview on 7/23/24, at 9:26 a.m., the Food Service Director Employee E3 stated that she was aware of the past weekend trays being late and that she could not work every day, twelve hours a day; it's hard when you don't have any staff to run a kitchen; the hotplate warmers sometimes work and sometimes don't; staff just don't work together; how do you make them, they have to learn.</p> <p>During an observation on 7/23/24, the lunch delivery identified on the [NAME] Meal Delivery Log indicated the at the lunch cart delivery service on the 2 East Nursing unit cart delivery was to be at 12:08 p.m., and 12:15 p.m., staff stated that they only get one cart. The cart did not arrive until 12:30 p.m., fifteen minutes after the posted arrival time.</p> <p>During an interview on 7/23/24, at 12:30 p.m., the Director of Nursing, Nursing Home Administrator and Lucent Regional Manager Employee E5 confirmed that the the facility failed to ensure that meals were served at regularly scheduled times for three of three days identified (7/20/24, 7/21/24 and 7/23/24).</p> <p>28 Pa. Code: 211.6 (c) Dietary services.</p>		