STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395620	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Healthcare and Rehabilitation Center	951 Brodhead Road Coraopolis, PA 15108

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to make certain call bells were in reach for two of seven residents as required (Resident R30 and R108). Findings include: The facility policy Call Lights dated 4/17/24, indicated when a resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Review of Resident R30's clinical record indicated admission to the facility on [DATE]. Review of Resident R30's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/19/23, indicated diagnoses of hypertension (high blood pressure) hyperlipidemia (high fats in the blood) and depression. During an interview and observation on 9/16/24, at 10:05 a.m. Resident R30's was sitting in her wheelchair, her call light button was wrapped on enabler/side rail assist bar on the other side of bed. When Resident R30 was asked what she would do if she needed help, she stated I don't know, I can't reach have my bell. Interview on 09/16/24 at 10:25 a.m. Licensed Practical Nurse (LPN) Employee E2 confirmed the call bell was on the other side of the bed out of Residents R30's reach. Review of admission record indicated R108 admitted to the facility on [DATE]. Review of R108's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/5/24, indicated the diagnoses of hemiplegia of right dominant side (paralysis of right side), aphasia following cerebral infarction (comprehension and communication (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain), and dysphagia (difficulty swallowing). Observation on 9/16/24, at 10:39 a.m. Resident R108's call bell was observed not in reach and hanging off the right-side bed rail. Resident R108 confirmed he was unable to reach his call light. Interview on 9/16/24, at 10:50 a.m. LPN Employee E3 confirmed facility failed to make certain call bells were in reach for two of seven residents as required. (Resident R30 and R108). (continued on next page)

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
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. 28 Pa Code: 201.29 (l)(o) Resident rights.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to assure physician orders, residents' Physician Order for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments), was available for one of four residents (Residents R336). Findings include: The facility Advanced Directives policy dated 4/17/24, indicated that this policy shall establish guidelines for medical treatment decision-making that both recognize and respect the residents right of self-determination. Review of Resident R336's clinical record indicate an admitted [DATE], with diagnoses including diabetes (high sugar in the blood), hypertension (high blood pressure), and hyperlipidemia (high fat in the blood), Review of Resident R336 clinical record 9/18/24, at 12:30 p.m. failed to reveal a POLST (Physician Orders for Life Sustaining Treatment) or a physician order for code status. During an interview on 09/18/24, at 12:37 p.m. Licensed Practical Nurse Employee E3 confirmed there was not a code status for Resident R336 and that the facility failed to assure physician orders, residents' Physician Order for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments), was available for one of four residents (Residents R336). 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.10(c) Resident care policies

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 49469 Based on review of facility policy, observations, and staff interview it was determined that the facility failed to provide privacy and confidentiality of resident healthcare information for twelve of thirty-seven residents (Residents R3, R28, R33, R57, R76, R81, R94, R117, R122, R123, R131 and R435). Findings include: The facility policy Health Insurance Portability and Accounting Act of 1996 (HIPPA) dated 4/17/24, indicated this facility will keep information regarding a resident ' s health private and confidential. The facility policy Resident rights dated 4/17/24, indicates this facility will protect and promote the rights of each resident, including but not inclusive to privacy and confidentiality. The facility policy Coronavirus (Covid-19) dated 4/17/24, indicated this guidance is to provide the facility an overview of key actions required to reduce risk and prevent the potential spread of infections to patients and staff. Procedure includes but not inclusive to placing appropriate signage outside of room to identify that precautions are needed. During an observation on 09/17/24, at 2:33 p.m. with Registered Nurse (RN) Employee E14 the following was observed: . A sign printed in red ink on the outside of Resident R3's door indicating infection with COVID-19. . A sign printed in red ink on the outside of Resident R57's door indicating infection with COVID-19. . A sign printed in red ink on the outside of Resident R76's door indicating infection with COVID-19 . A sign printed in red ink on the outside of Resident R81's door indicating infection with COVID-19 . A sign printed in red ink on the outside of Resident R122's door indicating infection with COVID-19. . A sign printed in red ink on the outside of Resident R123's door indicating infection with COVID-19. . A sign printed in red ink on the outside of Resident R435's door indicating infection with COVID-19. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/17/24, at 2:33 p.m. RN Employee E14 stated we should never say what the person has and confirmed the facility failed to keep information regarding a resident's health private and confidential. During an observation on 9/17/24, at 2:51 p.m. with RN Employee E3 the following was observed: . A sign printed in red ink on the outside of Resident R28's door indicating infection with COVID-19. . A sign printed in red ink on the outside of Resident R33's door indicating infection with COVID-19. . A sign printed in red ink on the outside of Resident R81's door indicating infection with COVID-19. . A sign printed in red ink on the outside of Resident R94's door indicating infection with COVID-19. . A sign printed in red ink on the outside of Resident R117's door indicating infection with COVID-19. During an interview on 9/17/24, at 2:52 p.m. RN Employee E3 stated I was questioning these signs as well, as they are new, we had green signs for enhanced droplet precaution on covid rooms and confirmed that the facility failed to keep information regarding a residents health private and confidential as required. 28 Pa. Code 201.29(j) Resident rights. 28 Pa. Code 211.5(b) Clinical records.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46337 Based on review of resident clinical records, and staff interviews, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for two of two residents (Resident R41, and R107). Findings Include: A review of the facility policy Documentation of Discharges or Deaths last reviewed 4/17/24, indicated all discharges will be sent to the Office Ombudsman's office at the end of the month. Review of Resident R41's clinical record indicated the resident was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of hypertensive heart disease without heart failure (long-term condition that develops over many years in people who have high blood pressure), dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident R41's clinical record revealed that the resident was transferred to the hospital on 7/17/24, and returned to the facility on [DATE]. Review of Resident R41's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 7/17/24. A review of Resident R41's clinical record indicated the facility failed to include documented evidence that the facility provided a written notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of Resident R107's clinical record indicated the resident was admitted to the facility on [DATE], with diagnoses of anxiety, depression, and high blood pressure. Review of Resident R107's clinical record revealed that the resident was transferred to the hospital on 10/21/23 and returned to the facility on [DATE]. A review of Resident R107's clinical record indicated the facility failed to include documented evidence that the facility provided a written notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. During an interview on 7/31/24, at 10:54 a.m. Social Service Director Employee E1 stated I do not notify the ombudsman of a transfer to the hospital, I didn't know that they needed to be notified. During an interview on 9/18/24, at 12:32 p.m. information disseminated to the Nursing Home Administrator, regarding the notice to a representative of the Office of the Long-Term Care Ombudsman Division was not provided for two of two residents (Resident R41 and R107). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for two of two resident hospital transfers (Residents R41 and R107). Findings Include: Review of the facility Transfer Notice of Bed Hold Policy and Readmission policy dated 4/17/24, indicated the facility will provide written information to the resident or legally responsible party that specifies the bed-hold policy prior or at the time of transfer to a hospital or other anticipated temporary leave. Review of Resident R41's clinical record indicated the resident was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of hypertensive heart disease without heart failure (long-term condition that develops over many years in people who have high blood pressure), dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident R41's clinical record revealed that the resident was transferred to the hospital on 7/17/24, and returned to the facility on [DATE]. Review of Resident R41's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 7/17/24. During an interview on 9/18/24, at 10:48 a.m. LPN Employee E2, confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for Resident R41's hospital transfers. Review of Resident R107's clinical record indicated the resident was admitted to the facility on [DATE], with diagnoses of anxiety, depression, and high blood pressure. Review of Resident R107's clinical record revealed that the resident was transferred to the hospital on 10/21/24 and returned to the facility on [DATE]. Review of Resident R107's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 10/21/24. During an interview on 9/18/24, at 1:05 p.m. LPN Nurse Manager, Employee E3 confirmed the facility failed to provide documented evidence that the resident or resident's representative was notified of the facility bed-hold policy for Residents R107. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	28 Pa. Code: 201.29(b)(d)(j) Resident rights.

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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** 27424 Based on review of clinical records and staff interview it was determined that the facility failed to provide care and services according to accepted standards of clinical practice in the identification of a resident's diagnosis of schizoaffective disorder for one of five residents (Resident R45). Findings include: Review of the American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Fifth Edition, Schizoaffective Disorder, Diagnostic Criteria included, but is not limited to: A. An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion-A of schizophrenia: --Two (or more) of the following, each present for a significant portion of time during a one-month period (or less if successfully treated). At least one of these must be (1), (2), or (3): --1. Delusions. --2. Hallucinations. --3. Disorganized speech (e.g., frequent derailment or incoherence). --4. Grossly disorganized or catatonic behavior. --5. Negative symptoms (i.e., diminished emotional expression or avolition). B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness. C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness. D. The disturbance is not attributable to the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. Review of the Resident R45's clinical record revealed the resident was admitted to the facility with an original admitted [DATE]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the History and Physical (H&P, comprehensive assessment of resident completed by provider on the initial resident visit) dated 11/10/16, included diagnoses of acute right middle cerebral artery (MCA) infarct with left hemiparesis (Stroke that stops the blood flow to one of the largest arteries in the brain), and hemiparesis (muscle weakness or partial paralysis on one side of the body). Resident R45 was admitted for rehabilitation. A diagnosis of Major Depressive Disorder MMD (a serious mood disorder that affects your whole body, including your mood and thoughts) is documented on the H&P. Review of the PASRR (Pennsylvania Preadmission Screening Resident Review Identification) All applicants to a Medicaid certified nursing facility be evaluated for a serious mental illness or intellectual disability and is a Federal PASRR Regulations 42 CFR 483.106. This was completed on 11/9/16, section III identifies the Major Depressive Disorder, single episode and in section VIII indicated a negative screen for Serious Mental Illness. This document was reviewed by the Department of Public Welfare on 11/22/16. Review of R45 care plan of 11/11/16, does not include planning or interventions for a Serious Mental Illness. Review of Psychiatric Progress Note of 12/3/20, diagnosis includes Psuedobulbar Affect (PBA may be caused by neurological damage related to a neurologic condition or brain injury), depression, anxiety, psychosis, delusions, and hallucinations. Review of Psychiatric Progress notes dated 3/10/21, indicates a diagnosis of Schizoaffective Disorder. Review of the admission Diagnosis from 11/9/16 through 1/19/24 indicates Schizoaffective Disorder diagnosis was added to the record on 3/11/21. Review of the documentation prior to 3/10/21, failed record a diagnosis of Schizoaffective Disorder until 3/10/21. During an interview with Social Services at E8 and E9 on 9/20/24, 11 a.m., a request was made for additional documentation of the Serious Mental Illness of Schizoaffective Disorder onset prior to 3/10/21, and was not able to be produced. During an interview on 9/20/24, at 11:54 a.m. with the Nursing Home Administrator and Director of Nursing a request was made for additional documentation of the Serious Mental Illness of Schizoaffective onset prior to 3/10/21. The Nursing Home Administrator provided a new PASRR Screening with a date of 1/15/24. This document failed to acknowledge under section III any diagnosis of a Serious Mental Illness (this would include Schizoaffective Disorder). The administrator confirmed this document (PASRR) was not in the medical record and that it was part of an email documentation. No other documents were produced. Confirming the facility did not have documented evidence of a practitioner diagnosing the resident with schizoaffective disorder according to professional standards for one of five residents. 28 Pa. Code 211.2 (a) Physician services. 28 Pa. Code 211.5 (f)(g)(h) Clinical records.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 35785 Based on review of facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to provide adequate supervision resulting in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one out of three sampled residents (Closed Resident Record CR132). Findings include: The facility Resident elopement policy dated 4/17/24, indicated that elopement is defined as a resident leaving the physical structure of the facility without the knowledge of facility staff. Review of Closed Resident Record CR132's admission record indicated he was admitted on [DATE]. Review of Closed Resident Record CR132's initial nurse assessment dated [DATE], indicated he was admitted with diagnosed that include chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination), hyperlipidemia (elevated lipid levels within the blood), and generalized muscle weakness. This is the most current assessment upon his admission. Review of Closed Resident Record CR132's clinical nurse progress note dated 6/22/24, indicated that he was in room and tearful. CR132 asked the nurse to try to call his son because he cannot get a hold of him and he thinks something might be wrong. Staff called his son. There was no answer. Staff left a message requesting a return call. Review of Closed Resident Record CR132's clinical nurse progress note dated 6/23/24, indicated Closed Resident Record CR132 was not in the facility. Review of Closed Resident Record CR132's clinical nurse progress note dated 6/23/24, indicated a late entry note for 6/22/24: At approximately 6:00 p.m. Closed Resident Record CR132 was not found in his room and could not be located in the building. Registered Nurse (RN) Employee E13 notified Nursing Home Administrator (NHA) and Director of Nursing (DON) and also called a code and grounds searched. DON and NHA arrived on site followed by local Police. Closed Resident Record CR132 was last seen in hall near his room at approximately 5:30 p.m. when staff had conversation with him listening to his concerns about his son. No verbal mention or ideation of elopement risk observed during that conversation. Subsequent investigation by Police did indeed locate Resident with son. Please refer to written Witness Statement for further details. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of investigation documents dated 6/22/24, indicated that Agency Licensed Practical Nurse (LPN) Employee E10 provided the following statement: At approximately 5:45 p.m. Agency Licensed Practical Nurse (LPN) Employee E10 was entering the facility from break. Upon entering, she witnessed CR132 trying to transfer from a travel wheelchair to his wheelchair. She asked if she could assist him. He agreed. She transferred him and pushed him to his room. CR132 was telling LPN he was waiting for one of his sons. After she exited his room, Agency Licensed Practical Nurse (LPN) Employee E10 informed his nurse what she witnessed and explained that CR132 was not in his room. She went back to the nurse station. A half hour passed and she realized she forgot something from her car. She went to her car and came back to the nurse unit 15 minutes later. A nurse asked if Agency Licensed Practical Nurse (LPN) Employee E10 if she seen Resident CR132. She was informed he was not in his room. Staff could not locate him. She did not see him but recalled seeing a car pull off from the front of the facility. Agency Licensed Practical Nurse (LPN) Employee E10 then started searching. Review of investigation documents dated 6/22/24, found a LOA (leave of absence) form signed out for 6/22/24, ineligible upon review for Closed Resident CR132. Review of investigation documents dated 6/22/24, indicated that CR132 son was contacted. The son stated CR132 was with the son. The son refused to return the resident and refused to sign AMA (against medical advice) discharge documentation. Review of Closed Resident Record CR132's care plans dated 6/24/24, indicated to assess cognitive status and instruct on safety measures. During an interview on 9/18/24, at 11:59 a.m. the Nursing Home Adminstrator (NHA) stated: his son said he was signing Closed Resident Record CR132 out. The son said he was not bringing him back. The resident did come back to the hospital. Whenever we came in, we looked through the LOA (leave of absence) book, he signed out the LOA form on a different resident. During an interview on 9/19/24, at 11:03 a.m. Nurse aide (NA) Employee E11 stated the following: I never saw Closed Resident Record CR132. I was not assigned to him. I was outside on break. I got off at 7:00 p.m. , so it must of been after 5:00 p.m. I saw a car pull in fast; it got my attention. Whoever the person was in the car, was trying to look in my car. The car pulled in front of the door. The guy went in. I was not paying attention. When I looked up again, i saw the Closed Resident Record CR132's son get back in the car. When I got off break, they said they were missing a resident. It was probably 5:15 p.m. when staff started looking. They walked to the local Wal-mart, staff looked in their cars, looked at the bar across the street. He was in the nursing home earlier. I did not even provide a statement. During an interview on 9/19/24, at 11:49 a.m. Nurse aide (NA) Employee E12 stated the following: earlier that day, CR132 kept telling us he was leaving. I took his dinner, around 4:30 p.m. to him. After dinner, I was with another resident. Around 5:15 p.m. i did not see Closed Resident Record CR132 in his room. I reported him missing to the nurse. We started looking for him, NHA and DON were called, and they started looking for him. We looked at Wal-mart, across the street, down stairs in activities. I don't know if this was an elopement. He would say he was leaving every day. No, I did not see him physically trying to get out and I would have stopped him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395620	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Healthcare and Rehabilitation Center	951 Brodhead Road Coraopolis, PA 15108

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24, at 12:21 p.m. Agency Licensed Practical Nurse (LPN) Employee E10 phone interview was attempted and a voice message left for the staff. During a phone interview on 9/19/24, at 2:47 p.m. Registered Nurse (RN) Employee E13 stated the following: I have a statement that I kept. The simple answer is I was the nurse on the South hall. I was doing medication pass and I was on the cart that day. I came upon Closed Resident Record CR132 room, he seemed a little depressed. I spoke to him and to see what his concerns were. He mentioned to me that he did not need to be at the home. I then went about and did the rest of my med pass. I went back around to see if he was in room around 5:30 p.m. I walked around the whole building and they could not find him. I notified the supervisor. We had staff looking around the building. Must of searched for him around 6:00 p.m. At the time , I believed it was an elopement. I worked 3-11:00 p.m. that day. The police were contacted and a later time, we had in-service about elopement. Closed Resident Record CR132 was not exhibiting exit seeking behaviors. The police were called and they did an investigation and we tried calling the family. there was no answer. He was found with his son. During an interview on 9/19/24, at 2:58 p.m. information was disseminated to the Nursing Home Administrator (NHA) and Director of Nursing (DON) that the facility failed to provide adequate supervision for Closed Resident Record CR132 resulting in an elopement. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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	395620	A. Building B. Wing	09/20/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on facility policy, clinical record review, and interview, the facility failed to have physician order specifications relating to size of indwelling catheter for one of three residents (Residents R103). Findings include: Review of facility policy Indwelling Foley Catheter, Appropriate Use Protocol dated 4/17/24, indicated indwelling catheters will be only changed if needed due to leakage or becoming dislodged or clogged. Review of the facility policy Medication and Treatment Orders dated 4/17/24, indicated treatment orders will contain what is to be done, frequency, and duration of treatment. Review of Admission record indicated Resident R103 was admitted to the facility on [DATE], with diagnoses of high blood pressure, kidney insufficiency, and depression. Review of Resident R103's care plan dated 12/12/23, indicated the resident had a foley catheter (a tube inserted in the bladder to drain urine.) Review of Resident R103's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/16/24, indicated the diagnoses were current. Review of Resident R103's physician order dated 9/12/24, indicated the resident had an indwelling foley catheter due to blockage. The resident's physician order failed to include specifications of what size catheter and balloon for the indwelling urinary catheter. During an interview on 9/18/24, at 12:32 p.m. information disseminated to the Director of Nursing (DON) regarding the facility's failure to have physician order specifications relating to size of indwelling catheter for one of three residents (Resident R103). 28 Pa. Code 211.10(c)(d) Resident Care Policies 28 Pa. Code 211.12 (d)(2) Nursing Services 28 Pa. Code 211.12(d)(1)(5) Nursing Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395620	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on observations, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to obtain physician's orders, conduct ongoing accurate assessments and failed to obtain a consent to ensure that enabler/side rail assist bars were used to meet residents' needs and the risks associated with enabler bar/side rail assist bar usage for two of three residents (R30 and R75). Findings include: Review of facility policy Proper Use of Enabler Bars dated 4/17/24, indicated side rails may be used as resident mobility aids and the use of side rails as restraints, will not be used unless necessary to treat a medical symptom. Guidelines include but are not inclusive to: -An assessment will be made to determine the resident's symptoms or reason for using side rails. -Informed consent for the use of less restrictive devices will be obtained from the resident or legal representative per facility protocol. Review of Resident R30's clinical record indicated admission to the facility on [DATE]. Review of Resident R30's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/19/23, indicated diagnoses of hypertension (high blood pressure) hyperlipidemia (high fats in the blood) and depression. Observation on 9/16/24, at 10:05 a.m. bilateral enabler/side rail assist bars present on Resident R 30's bed. Review of Resident R30's clinical record failed to reveal a current physician order for the use of enabler/side rail assist bar. During an interview on 9/19/24, at 10:28 a.m. Licensed Practical Nurse Employee E3, confirmed Resident R30 did not have current physician orders for enable/side rail assist bars. Review of the Resident R75's clinical record indicated admission to the facility on [DATE]. Review of Resident R57's Minimum Data Set assessment dated [DATE], indicated diagnosis of multiple sclerosis (autoimmune disease that affects the central nervous system) mental disorder and disease of the skin. During an interview and observation on 9/16/24, at 10:18 a.m. Resident R75 was in bed a right-side enabler/side rail assist bar was observed. Resident R75 stated the left enabler/side rail assist bar was getting replaced. (continued on next page)

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	395620	A. Building B. Wing	09/20/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident R75 physician orders unable to locate enabler/side rail assist bar orders. A review of resident R75's clinical record failed to reveal a Side Rail Assist Bar Evaluation and consent for Resident R75's enabler/side rail assist bar. During an interview on 09/20/24, at 11:20 a.m. the Director of Nursing stated, we don't do orders for enabler/side rail assist bars, and confirmed the facility failed to conduct ongoing accurate assessments to ensure that enabler/side rail assist bars were used to meet residents' needs and the risks associated with enabler bar usage for two of three residents (R30 and R75). 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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	395620	A. Building B. Wing	09/20/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, Nursing staff personnel records, nurse training documentation and staff interview, it was determined that the facility failed to ensure that nursing staff received annual in-service education for one out of six nursing personnel (Registered Nurse Employee E5). Findings include: The facility In-service training policy dated 4/17/24, indicated that the facility will provide in-service training for all personnel. All mandatory in-service requirements must be completed annually as a condition of continued employment. Training topics include residents rights, abuse, neglect and exploitation, behavioral health, infection control, compliance and ethics, effective communication, and dementia management. Review of Registered Nurse (RN) Employee E5's personnel record indicated she was hired to the facility on [DATE]. Review of Registered Nurse (RN) Employee E5's personnel record did not include annual in-services on resident rights, person centered care, communication, basic nursing skills, basic restorative services, skin and wound care, medication management, pain management, infection control, identification of changes in condition, and cultural competency. During an interview on 9/19/24, at 11:00 a.m. the Director of Human Resources Employee E4 confirmed that the facility failed to ensure that nursing staff received annual in-service education for one out of six nursing personnel (Registered Nurse Employee E5). 28 Pa Code: 201.14(a) Responsibility of licensee 28 Pa Code:201.18(a)(3) Management

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	395620	A. Building B. Wing	09/20/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to make certain medications were administered as ordered by the physician for one of of three residents (Resident R385). Findings include: A review of facility policy Medication administration dated 4/17/2024, indicated that medications are administered, as prescribed, in accordance with good nursing principles and practices and only persons legally authorized to do so to comply with Federal Laws governing Medication Administration and in order to ensure the safe, accurate and timely administration of medications. A review of Resident R385 admission record indicated that she was admitted to the facility on [DATE]. A review of Resident R385's Minimum Data Set assessment (MDS - a periodic assessment of care needs) dated 8/2/24, indicated she had with diagnoses that included diabetes (a metabolic disorder impacting organ function related to glucose levels in the human body), chronic kidney Disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination) and morbid obesity. A review of Resident R385's physician original order 4/5/24, indicated to give Jentadueto (combination of two diabetes medication to lower blood sugar) 2.5 MG (milligram) twice daily. A review Resident R385's the Medication Administration Record (MAR) dated September 2024, indicated that Resident R385 Jentadue to medication was not administered for the 9/10/2024 A review Resident R385's clinical progress notes dated 9/10/2024, indicated that the medication was reordered by Licensed Practical Nurse (LPN) Employee E6. There was no documented evidence on this date that the provider was notified. During the Resident Council Meeting on 9/17/2924 at 1:30 p.m. a resident expressed concern of the facility not having her diabetic medication available. During an interview with Resident R385 in her room on 9/18/2024 10:30 a.m. she stated that the facility did not have her diabetic medication (Jentadueto) available and was told by the staff it was being reordered. During an interview on 9/18/2024, the Certified Registered Nurse Practitioner (CRNP) Employee E7 and the Director of Nursing reported that she was notified of the missed dose and the reorder of the medication with confirmation that there was no documentation in the record of this notification. The Director of Nursing reported the staff will document the details of the notification. During an interview on 9/19/2024 at 8:36 a.m the Director of Nursing confirmed that the facility failed to provide diabetic medication per physician order for Resident R385. (continued on next page)

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	395620	A. Building B. Wing	09/20/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (c)(1)(3) Nursing Services.

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	395620	A. Building B. Wing	09/20/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policies, observations and staff interview it was determined that the facility failed to the failed to ensure medications were not left unattended at the bedside for three of three of seven residents (Residents R36, R50 and R98). Findings include: Review of the facility Medication Administration policy dated 4/17/24, indicated medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so to comply with federal laws governing medication administration and in order to ensure safe, accurate, and timely administration of medications. In order for residents to self-administer medications, an attending physician must authorize to do so in accordance with procedures for self-administration of medications. Review of the facility Storage of Medications policy dated 4/17/24, indicated medications are stored in a safe, secure, and orderly manner in accordance with federal and state regulations and facility policies. During an observation and interview on 9/16/24, at 9:57 a.m. one round white pill was observed unattended on Resident R36's bedside table in a pill cup. Resident R36 indicated the nurse walked out before she finished taking her pills. During an interview on 9/16/24, at 10:00 a.m. Licensed Practical Nurse (LPN), Employee E1 confirmed the facility failed to properly store and secure medications. Review of Resident R50's clinical record indicated admission to the facility on [DATE]. A review of Resident R50's Minimum Data Set (MDS - a periodic assessment of care needs) dated 0/00/00, indicated diagnoses of Chronic Obstructive Pulmonary Disease (lung disease that damages the airways and air sacs in the lungs making it difficult to breath) and respiratory failure (condition when the lungs can ' t get enough oxygen into the blood). During an observation and interview on 9/16/2024, at 10:00 a.m. two inhalers were noted on Resident R50's overbed table, one labeled as Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder and another labeled Tiotropium Bromide Monohydrate 18 MCG Capsule. Review of Resident R50's physician orders indicated Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder inhale 1 puff by mouth every 12 hours and Tiotropium Bromide Monohydrate 18 MCG Capsule (inhale contents of 1 capsule by taking 2 separate inhalations via handihaler device once daily). Review of Resident R50's physician orders did not include self-administration of medications or instructions to leave at bedside. (continued on next page)

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	395620	A. Building B. Wing	09/20/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/16 /24 at 10:03 a.m. LPN Employee E6 stated resident is alert and can keep them at the bedside. LPN Employee E6 removed the meds and confirmed the facility failed to properly store and secure medications. Review of Resident R98's clinical record indicated an admitted [DATE]. A review of Resident R98's Minimum Data Set, dated dated dated [DATE], indicated diagnoses of hypertension (high blood pressure), anxiety, and dry eye syndrome. During an observation and interview on 9/16/24 at 10:00 a.m. a bottle of systane eye drops were noted on resident ' s bedside table. Review of Resident R98's physician orders did not include self-administration of medications or instructions to leave at bedside. During an interview on 9/16/24, at 10:05 a.m. LPN Employee E2 stated I don ' t think she has an order for those, I'm assuming her son brought them, removed from room and confirmed the facility failed to properly store and secure medications. During an interview with on 9/17/24, at 9:30 a.m. the Director of Nursing confirmed that the facility failed to store drugs and biologicals in a safe, secure, and orderly manner for three of seven residents (Residents R50, R98 and R36). 28 Pa Code: 211.9 (a) Pharmacy services. 28 Pa code: 211.12 (d) (1) (5) Nursing services.

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	395620	A. Building B. Wing	09/20/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to properly disinfect a respiratory equipment spacer (spacer- a plastic tube with a mouthpiece on one end, allows the person more time to inhale allowing medication to enter the lungs more efficiently) prior to placing in medication cart for one of three residents (Resident R136) and failed to prevent cross contamination during a dressing change for one of three residents (Resident R90). Findings Include: Review of the Aero Chamber Z STAT manual cleaning instructions for mask and mouthpiece chambers indicate: -Soak the parts for 15 minutes in a mild solution of liquid dish detergent and lukewarm clean water. -Agitate gently. -Rinse parts in clean water. -Dishwasher safe, avoid heated dry over 158*, parts on top rack only. -Do not boil or sterilize. -Shake out excess water from the parts and allow to air dry in a vertical position. -Ensure parts are dry before reassembly. Review of facility policy Oral Inhalation Administration) reviewed 4/17/24, indicated to allow for safe, accurate, and effective administration of medication using an oral inhaler (with or without a spacer/chamber) or nebulizer. Procedures include but not inclusive to: -If using a spacer, wash spacer according to manufacture directions. Observation of medication pass on 9/17/24, at 10:00 a.m. Licensed Practical Nurse (LPN) Employee E2 administered Resident R136 medications that included an albuterol inhaler with spacer. After inhaler administration LPN Employee E2 placed the spacer into a plastic bag and placed into drawer on medication cart. During an interview on 9/17/24, at 10:13 a.m. LPN Employee E2 confirmed the spacer was not cleansed after use and was placed directly into bag then placed on to cart. LPN Employee E2 stated I have asked several times what to do, I was bleaching them and confirmed the facility failed to properly disinfect respiratory equipment for Resident R136. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395620	A. Building B. Wing	09/20/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R90's clinical record indicated an admitted [DATE], indicated diagnosis of diabetes (high sugar in the blood), anemia (low iron in the blood) and open wound left foot. Review of physician orders dated 9/6/24, indicated Cleanse left foot amputation site with Vashe moistened gauze allow to sit on wound for one minute, cover with collagen then silver alginate cover with dynamo and wrap with Kling daily. During an observation on 9/18/24, at 10:05 a.m. a dressing change for resident R90 the following cross contamination opportunities were observed. Licensed Practical Nurse (LPN) Employee E2 took the bottle of Vashe wound cleanser into Resident R90's room, placed on bedside stand the poured into cup. A barrier was not placed under the wound prior to cleansing, LPN Employee E2 applied the collagen, silver alginate, covered with dynamo and wrapped with Kling. LPN Employee E2 then removed gloves used hand sanitizer and placed new gloves to remove discard from tray table. LPN Employee E2 did not clean off tray table after removal of supplies. During an interview completed on 9/18/24, at 10:34 a.m. LPN Employee E2 confirmed to taking the bottle of Vashe wound cleanser into resident R90's room and replacing it into treatment cart, not placing a barrier under wound prior to cleansing, failing to complete hand hygiene after the cleansing of wound, and failing to cleanse tray table after removal of supplies LPN Employee E2 confirmed the facility failed to prevent cross contamination during a dressing change for one of three residents (Resident R90). 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)(1)(2)(3) Nursing Services.