

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/21/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Masonic Village at Sewickley		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Masonic Drive Sewickley, PA 15143	
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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on review of facility policy, observations and staff interview, it was determined that the facility failed to determine it was safe to self-administer medications for one of three residents (Resident R6). Findings include: Review of the facility policy Resident Self -Administration of Medications last reviewed 8/8/24, indicated residents will be permitted to self-administer medication after evaluation by their interdisciplinary team and approval from their medical provider. If the interdisciplinary team indicates that a resident is able to safely self-administer medications the provider will write an order authorizing the resident to self-administer the medication. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/14/25, indicated reentry to facility on 10/30/24, with diagnoses of hypertension (high blood pressure), diabetes (high sugar in the blood) and chronic obstructive pulmonary disease (COPD- causes breathing problems). During a medication pass observation completed on 7/29/25, at 9:24 a.m. Licensed Practical Nurse (LPN) Employee E3 entered Resident R6's room a can of simply nasal spray was observed on the over the bed table. LPN Employee E3 removed the nasal spray returned to medication cart to check resident's orders and stated, He does not have orders for this and confirmed that the facility failed to obtain physician orders for medication self-administration for one of three residents (Residents R6). During an interview completed on 7/29/25, at 2:00 p.m. the Director of Nursing confirmed Resident R6 did not have a current order or an interdisciplinary assessment to self - administer medications and that the facility failed to determine it was safe to self-administer medications for one of three residents (Resident R6). 28 Pa code: 211.12 (d) (1) (5) Nursing services.		

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility documents, clinical record, and staff interviews, it was determined that the facility failed to ensure a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form were provided in a timely manner for two of three residents (Resident R32 and CR Resident R333). Findings include: Review of facility policy Informing the Resident of Medicare A/Skilled Managed Care Denial dated 8/8/24, indicated the policy is to protect the rights of each resident, it is required by a facility to provide beneficiaries advanced notice that care and services will not be or will no longer be covered by their Medicare Part A or Managed Skilled Care benefit. The facility has established this policy and the associated procedure to ensure that notices of Medicare non-coverage are issued timely and in adherence with the guidelines. Review of Resident R32's admission record indicated the resident was admitted to the facility on [DATE]. Review of Resident R32's Minimum Data Set (MDS - periodic assessment of care needs) dated 7/8/25, included diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), high blood pressure, and arthritis. Review of the SNF ABN form indicated services will end 7/28/25. Resident R32's representative signed the SNF ABN on 7/28/25. The facility failed to issue the SNF ABN in a timely manner. Review of Resident CR Resident R333's admission record indicated the resident was admitted to the facility on [DATE]. Review of Resident CR Resident R333's MDS dated [DATE], included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and depression. The facility failed to provide a completed SNF ABN for CR Resident R333 that should have been given. During an interview on 7/28/25, at 1:21 p.m. the Director of Nursing stated, This resident does not have one. We cannot find a SNF ABN for her. During an interview on 7/29/25, at 10:38 a.m. the Nursing Home Administrator confirmed the facility failed to ensure a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form were provided in a timely manner for two of three residents (Resident R32 and CR Resident R333). 28 Pa. Code 201.24 (b) admission Policy. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a) Resident Rights.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of five resident hospital transfers (Residents R4, and R8). Findings include: Review of the facility policy Bed Hold, Transfer, Discharge and readmission Policy for Nursing Care dated 8/8/24, indicated appropriate information will be communicated to the receiving health care provider/facility that will be caring for the resident. The information should include but is not limited to: 1. Contact information of the provider responsible for the care of the resident 2. Resident representative/POA (power of attorney) Contact information 3. Copy of Advanced Directive 4. All special instructions/precautions for ongoing care 5. Comprehensive care plan goals/discharge care instructions 6. Any other information that will ensure a safe and effective transition of care including the resident's discharge plan Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/15/25, indicated diagnoses of lung cancer, stroke (damage to the brain from an interruption of blood supply), and anemia (the blood doesn't have enough healthy red blood cells). Review of the clinical record indicated Resident R4 was transferred to the hospital on 3/7/25, and returned 3/18/25. Review of Resident R4's clinical record failed to include documented evidence that the facility had communicated specific information to the receiving health care provider for the resident's transferred and expected return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Interview on 7/30/25, at 12:34 p.m. the Director of nursing confirmed the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for Resident R4. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R8's MDS dated [DATE], indicated diagnoses of fracture left femur, dysphagia (medical condition characterized by difficulty or discomfort in swallowing) and muscle weakness. Review of the clinical record indicated Resident R8 was transferred to the hospital on 5/22/25, and returned to the facility on 5/30/25. Review of Resident R8's clinical record failed to include documented evidence that the facility had communicated specific information to the receiving health care provider for the resident's transferred and expected return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 7/30/25, at 1:30 p.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of five residents sampled with facility-initiated transfers (Residents R4 and R8). 28 Pa. Code: 201.29 (a)(c)(3)(2) Resident rights.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interview, it was determined that the facility failed to obtain a physician order for two of five residents (Resident R18 and R19), and failed to follow the bowel protocol in a timely fashion for one of five residents (Resident R17). Findings include: Review of the facility policy Bowel Protocol dated 8/8/24, indicated treatment after 72 hours with no documented bowel movement:- the evening shift nurse should examine abdomen. If there are abnormal findings, give Senna (laxative) and notify the provider for further orders.-the day shift nurse the following day will determine and evaluate effectiveness of the Senna by reviewing documentation in the clinical record. For residents with no bowel movement (BM) the day nurse will perform an additional exam, notify the provider for further orders and give a Dulcolax suppository and document on the Medication Administration Record (MAR).-If the protocol is ineffective, this should be noted in the resident's medical record and provider should be notified. Review of the clinical record indicated Resident R17 was admitted to the facility on [DATE], with diagnoses that included high blood pressure, hyperlipidemia (high levels of fat in the blood), and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). Review of Resident R17's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/14/25, indicated the diagnosis remained current. Review of Resident R17's BM record for July 2025, indicated the following:-07/3/25 - Large BM-7/10/25 - Small BM - time lapse was seven days-7/16/25 - Small BM - time lapse was six days-7/17/25 - Large BM - -7/22/25 - Small BM - time lapse was five days. Review of Resident R17's clinical record indicated no evidence of abdominal assessments and or interventions for the bowel protocol implementation during this time until 7/21/25, the MAR indicated resident received bisacodyl 5mg (milligrams) by mouth every 24 hours as needed for constipation first provided on 7/21/25. Interview on 7/30/25, at 11:00 a.m. the Director of Nursing confirmed the facility failed to follow the bowel protocol in a timely fashion for one of five residents (Resident R17). Review of the clinical record indicated Resident R18 was admitted to the facility on [DATE], with diagnoses that included vascular dementia (Brain damage caused by multiple strokes), kidney disease and congestive heart failure (chronic condition where the heart muscle can't pump enough blood to meet the body's needs, leading to fluid buildup in the lungs and other tissues). Review of Resident R18's MDS assessment dated [DATE], indicated the diagnosis remained current. Review of Resident R18's nurse progress notes dated 6/6/25, 6/12/25, and 7/18/25, indicated that Resident R18 was on leave with family. Review of Resident R18's most recent physician orders indicate no order to go out on therapeutic leave. Review of the clinical record indicated Resident R19 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's (progressive brain disorder that causes memory loss, confusion, and other cognitive decline), hypothyroidism and repeated falls. Review of Resident R19's MDS assessment dated [DATE], indicated the diagnosis remained current. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R19's nurse progress notes dated 6/6/25, 6/12/25 and 7/18/25, indicated that Resident R19 was on leave with family. Review of Resident R19's most recent physician orders indicate no order to go out on therapeutic leave. During an interview on 7/30/25, at 1:30 p.m. the Director of Nursing confirmed that Resident R18, and R19 did not have an order for therapeutic leaves as required. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for two of three residents (Resident R17 and R77). Findings include: Interview with the Director of Nursing on 7/31/25, at 11:00 a.m. indicated the facility did not have a policy for assistive devices/splints. Review of the clinical record indicated Resident R17 was admitted to the facility on [DATE]. Review of Resident R17's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/14/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). Review of Resident R17's progress note dated 7/15/2025, 8:59 p.m. indicated resident returned from the Orthopedic appointment with a back brace that is to be removed at bedtime and a brace on his right hand that is to be left on at all times except for care. Skin protectant and gauze applied to under straps to help maintain skin integrity. Further review of Resident R17's progress notes failed to include documented evidence that the brace on the right hand was assessed on the day provided by the Orthopedic appointment and/or the appearance of the right hand upon return. Review of Resident R17's progress note dated 7/16/25, at 6:15 a.m. indicated notified by staff that resident was removing brace and skin appeared to be irritated. Skin tear noted to right hand below the thumb. Red area noted to the right outer wrist. Brace taken apart and lying next to resident. The resident repeating It hurts and had already removed brace from the right hand. The area was cleansed with saline, approximated skin tear flap secured with steristrips. Covered with wrap. Skin protectant applied to reddened area prior to right hand/wrist wrapped for skin protection. Brace reapplied. Message sent to physician; skin check every shift. Review of Resident R17's progress note dated 7/16/25, at 12:22 p.m. indicated brace removed from hand due to rubbing. Call placed to home medical provider as per directions given by Orthopedic physician's office as they did not have a larger brace available in office. Message left awaiting return call. Interview on 7/30/25, at 10:57 a.m. the Director of Nursing confirmed, We were so upset that the Orthopedic sent the resident with a splint that was too small, that later caused skin damage. Review of the clinical record indicated Resident R77 was admitted to the facility on [DATE], with the diagnosis of osteomyelitis (infection of the bone) of vertebra, thoracic region (back), depression and atrial fibrillation (irregular heart rhythm). (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R77's physician orders dated 7/21/25, indicated thoraco-lumbar sacral orthosis (TLSO-used to keep back extended after surgery or a spinal fracture) brace when out of bed. No directions specified for order. The orders failed to include interventions for monitoring of skin integrity under the brace. Review of Resident R77's current care plan failed to include interventions for monitoring of skin integrity under the brace. During an interview completed on 7/30/25, at 11:02 a.m. Licensed Practical Nurse Employee E1 confirmed the physician order failed to include monitoring of skin integrity under the brace and the care plan failed to include interventions for monitoring of skin integrity under the brace. Interview on 7/31/25, at 11:30 a.m. the Director of Nursing confirmed the failed to ensure a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for two of three residents (Resident R17 and R77) and could not provide documented evidence that the brace on the right hand was assessed on the day provided by the Orthopedic appointment for Resident R17. 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)(2)(3)(5) Nursing services.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on review facility policies, observations, clinical records, and staff interviews it was determined that the facility failed to make certain that appropriate treatments and services were provided for the use of an indwelling urinary catheter as required for three of four residents (Resident R11, R17, and R41). Findings include: Review of facility policy Continence Care Program and Indwelling Catheter Management dated 8/8/24/25, indicated drainage bags should be covered for dignity. Review of the clinical record indicated Resident R11 was admitted to the facility on [DATE]. Review of Resident R11's minimum data set (MDS - a periodic assessment of care needs) dated 6/30/25, indicated the diagnosis of hypertension (high blood pressure) obstructive uropathy (blockage of urinary flow) and Parkinson's disease (brain condition that causes slowed movements, rigidity and tremors). Review of the clinical record revealed Resident R11 had a physician's order dated 4/25/25, for an indwelling urinary catheter (closed sterile system inserted into the bladder to allow for urine drainage). Observation on 7/28/25, at 9:59 a.m. Resident R11 was lying in bed with a catheter connected to a drainage bag, the drainage bag failed to be covered as required. Interview on 7/28/25, at 10:04 a.m. Registered Nurse (RN) Employee E2 confirmed Resident R11's drainage bag was not covered as required. Review of the clinical record indicated Resident R17 was admitted to the facility on [DATE]. Review of Resident R17's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). Review of the clinical record revealed Resident R17 had a physician's order dated 7/25/25, for an indwelling urinary catheter. Observation on 7/28/25, at 9:42 a.m. Resident R17 was lying in bed with a catheter connected to a drainage bag. The drainage bag failed to be covered as required. Interview on 7/28/25, at 1:30 p.m. Registered Nurse (RN) Employee E2 confirmed Resident R17's catheter drainage bag was not covered as required. Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE]. Review of Resident R41's MDS dated [DATE], indicated diagnoses of high blood pressure, atrial fibrillation (irregular heart rhythm), and heart failure (heart doesn't pump blood as well as it should). Review of the clinical record revealed Resident R41 had a physician's order dated 7/1/25, for an indwelling urinary catheter. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 7/28/25, at 9:42 a.m. Resident R41 was lying in bed with a catheter connected to a drainage bag. The drainage bag failed to be covered as required. Interview on 7/28/25, at 1:40 p.m. Licensed Practical Nurse (LPN) Employee E3 confirmed Resident R41's catheter drainage bag was not covered as required. During an interview on 7/28/25, at 2:30 p.m. the Director of Nursing confirmed the facility failed to make certain that appropriate treatments and services were provided for the use of an indwelling urinary catheter as required for three of four residents (Resident R11, R17, and R41). 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)(2)(3)(5) Nursing services.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to provide adequate treatment and care for a peripheral inserted central catheter (PICC - a thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart) in accordance with professional standards of practice for one of two residents (Resident R77). Findings include: Review of the facility policy PICC and Midline Management and Protocol last reviewed 8/8/24, indicated with intermittent infusions (antibiotics) are flushed with 10 millimeter (ml) normal saline solution (NSS) then infuse medication. After medication is infused, flush with 10 ml NSS. Review of the clinical record indicated Resident R77 was admitted to the facility on [DATE], with the diagnosis of osteomyelitis (infection of the bone) of vertebra, thoracic region (back), depression and atrial fibrillation (irregular heart rhythm). Review of physician orders dated 7/26/25, indicated Cefepime HCl Solution 1-gram (GM)/50ml Use 1 gram intravenously (IV) every 12 hours for osteomyelitis until 08/09/2025, flush right upper arm (RUA) PICC prior and after infusion. The order failed to include the substance to use for the flush or the amount needed to flush. During an interview completed on 7/30/25, Licensed Practical Nurse (LPN) Employee E1 confirmed that Resident 77's orders failed to include the substance to use for the flush or the amount to flush and that the facility failed to provide adequate treatment and care for a PICC in accordance with professional standards of practice for one of two residents (Resident R77). 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing Services. 28 Pa. Code: 201.14(a) Responsibility of licensee.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for two of six residents (Resident R17 and R35). Findings include: Review of facility policy Oxygen Concentrator/Oxygen Tank dated 8/8/24, indicated to change the bottle and tubing weekly when oxygen concentrators are in use. Review of the clinical record indicated Resident R17 was admitted to the facility on [DATE]. Review of Resident R17's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/14/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). Review of the clinical record revealed Resident R17 had a physician's order dated 7/14/25, for oxygen via nasal cannula (a thin flexible tube that goes around your head and into your nostrils to provide supplemental oxygen) at 2 lpm (liters per minute) to keep oxygen saturation greater than 90 percent. Observation on 7/28/25, at 9:42 a.m. Resident R17 was lying in bed with oxygen concentrator in use with a nasal cannula. The date on the empty humidification bottle was 7/20/25. Interview on 7/28/25, at 1:30 p.m. Registered Nurse (RN) Employee E2 confirmed Resident R17's humidification bottle was empty and was not changed weekly as required. Review of the clinical record indicated Resident R35 was admitted to the facility on [DATE]. Review of Resident R35's MDS dated [DATE], indicated diagnoses of high blood pressure, heart failure (heart doesn't pump blood as well as it should), and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of the clinical record revealed Resident R35 had a physician's order dated 7/14/25, for oxygen via nasal cannula at 2 lpm (liters per minute to keep oxygen saturation greater than 90 percent. Observation on 7/28/25, at 11:35 a.m. Resident R35 was sitting up in room with oxygen concentrator in use with a nasal cannula. The date on the humidification bottle was 7/14/25. Interview on 7/28/25, at 1:30 p.m. Registered Nurse (RN) Employee E2 confirmed Resident R35's humidification bottle was not changed weekly as required. During an interview on 7/28/25, at 2:30 p.m. the Director of Nursing confirmed the facility failed to provide appropriate respiratory care for two of six residents (Resident R17 and R35). 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)(2)(3)(5) Nursing services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Masonic Village at Sewickley		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Masonic Drive Sewickley, PA 15143	
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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** Based on review of facility policy, observations and staff interviews, it was determined that the facility failed to properly store medical supplies in two of three medication rooms (Maple Place and [NAME] Court), and on two of three medication carts (Birch Place and [NAME] Court). Findings: Review of facility "Storage of Medications" policy dated [DATE], indicated medications and biologicals are stored safely, securely, and properly following manufactures recommendations or those of pharmacy. Insulin pens should be dated when fires opened. A pharmacy consultant or facility designee will monitor medication storage, medication records, and expiration dates. During a medication storage room review on [DATE], at 11:15 a.m. the following were observed: - A vial of tuberculin (medication used to detect a respiratory disease) was dated [DATE] and was expired in Maple Place medication storage room. During a medication cart review on [DATE], at 11:25 a.m. the following were observed: - Novolog Insulin Pen (used to treat diabetes-a metabolic disorder in which the body has high sugar levels for prolonged periods of time) had an expiration date marked [DATE], on Birch Place medication cart. - Insulin Lispro Pen (used to treat diabetes) was opened on [DATE] and did not include an expiration date, however, was expired on Birch Place medication cart. During an interview on [DATE], at 11:25 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed the above findings. During an interview on [DATE], at 2:30 p.m. the Director of Nursing confirmed that the facility failed to properly store medical supplies in two of three medication rooms (Maple Place and [NAME] Court), and on two of three medication carts (Birch Place and [NAME] Court). During an observation of the [NAME] Medication Room on [DATE], at 11:46 a.m. a tuberculin vial was noted to be opened and failed to be labeled with the date opened as required. Interview on [DATE], at 11:47 a.m. Licensed Practical Nurse (LPN) Employee E3 confirmed the TB vial was not dated as required. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated [DATE], indicated reentry to facility on [DATE], with diagnoses of hypertension (high blood pressure), diabetes (high sugar in the blood) and chronic obstructive pulmonary disease (COPD- causes breathing problems). Review of Resident R6's physician orders dated [DATE], indicated Basaglar (long-acting insulin) KwikPen Subcutaneous Solution Pen injector 100 UNIT/milliliter (ML) inject 6 units subcutaneously in the morning. During a medication pass observation completed on [DATE], at 9:24 a.m. Licensed Practical Nurse (LPN) Employee E3 prepared Resident R6's Basaglar KwikPen and placed on top of medication cart. LPN Employee E3 entered Resident R6's room with oral medications leaving the insulin pen sitting on top of the medication cart available to anyone passing by. During an interview completed on [DATE], at 9:39 a.m. LPN Employee E3 confirmed entering Resident R6's room and leaving the insulin pen sitting on top of the medication cart available to anyone passing by. 28 Pa Code: 211.9 (a)(1) Pharmacy services. 28 Pa code: 211.12 (d) (1) (5) Nursing services.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, resident clinical records and staff interviews it was determined that the facility failed to ensure a resident had the capacity to understand the terms of a binding arbitration agreement (a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) for one of three residents (Resident R14). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the admission record indicated Resident R14 was admitted to the facility on [DATE]. Review of Resident R14's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/12/25, indicated the diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), depression, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Resident R14's MDS assessment section C0200 BIMS score was a five, indicating severe impairment. Review of Resident R14's Binding Arbitration Agreement indicated that the resident signed the document on 11/6/24, with a severe cognitive impairment. Review of facility provided document labeled, Mandatory Arbitration Agreement, was reviewed. The document does not give the resident or the residents representative a decline section if they choose to decline signing the Arbitration Agreement. The document provided included: Mandatory Arbitration Agreement. Please read carefully. Mandatory Arbitration and a signature and date section. During an interview on 7/30/25, at 9:15 a.m. the Nursing Home Administrator (NHA) stated that all new admissions sign the Arbitration Agreement with their admission packet and Everyone signs it. When asked, What if they did not want to sign it? NHA replied, I don't know how to answer that question. I can see that it looks like we took away their choice by having all new admissions sign it. During an interview on 7/30/25, at 9:20 a.m. the NHA confirmed the facility failed to ensure a resident had the capacity to understand the terms of a binding arbitration agreement for one of three residents (Resident R14). 28 Pa. Code: 201.14(a)(c) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on facility policy review, review of Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for one of four quarterly meetings (Quarter One of 2025). Findings Include: The facility Quality Assurance and Performance Improvement (QAPI) policy dated 8/8/24, indicated it is the policy of the facility to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, resident quality of life and residents' choice and is based on the scope and complexity of services defined by the Facility Assessment. Review of Quality assurance and Performance Improvement sign in sheets and attendance records for Quarter One of 2025, failed to reveal the Director of Nursing was in attendance. During an interview on 7/28/25, at 2:35 p.m. the Director of Nursing confirmed that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for one of four quarterly meeting (Quarter One of 2025), as required. 28 Pa Code: 201.18(e)(1)(2)(3)(4) Management.		

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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. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, observation, and staff interviews, it was determined that the facility failed to prevent cross contamination during a medication pass for one of three residents (Resident R6), failed to prevent cross contamination and follow enhanced barrier precaution during a dressing change for one of three residents (Resident R7) and failed to properly monitor residents in room personal refrigerator temperatures for four of five residents (Resident R1, R34, R35, and R67) which created the potential for food borne illness. Findings include: Review of the facility policy Infection Transmission Prevention and Interventions last reviewed 8/8/24, indicated enhanced barrier precautions are used for residents that have a wound or wounds which require a dressing for treatment. Review of facility policy Refrigerator and Freezer Temperatures last reviewed 8/8/24, indicated all resident and medication refrigerators are monitored using an electronic monitoring system. Staff will notify administration when a resident brings their personal refrigerator into the facility. Nursing administration will ensure that a tag is placed inside the refrigerator to electronically monitor the temperature. The maintenance department reviews the temperature logs and services the refrigerators as needed. Using the refrigerator and monitor log staff will document the temperatures of refrigerators and freezers. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/14/25, indicated reentry to facility on 10/30/24, with diagnoses of hypertension (high blood pressure), diabetes (high sugar in the blood) and chronic obstructive pulmonary disease (COPD- causes breathing problems). Review of Resident R6's physician orders dated 5/8/25, indicated Acetaminophen extra strength oral tablet 500 milligrams (mg) give 1000 mg by mouth three times a day for chronic pain. During a medication pass observation completed on 7/29/25, at 9:24 a.m. Licensed Practical Nurse (LPN) Employee E3 was preparing Resident R6's medications. LPN Employee E3 dropped Resident R6's Acetaminophen on the medication cart surface. LPN Employee E3 picked the Acetaminophen up and placed into medication cup for administration. During an interview completed on 7/29/25, at 9:39 a.m. LPN Employee E3 confirmed dropping Resident R6's Acetaminophen on the medication cart surface and placing into medication cup for administration and that the facility failed to prevent cross contamination during a medication pass for one of three residents (Resident R6). Review of Resident R7's MDS dated indicated admission to the facility on 2/12/25, with the diagnosis of hypertension (high blood pressure), heart failure (the heart doesn't pump the way it should) and hyperlipidemia (high fat in the blood) Review of R7's physician orders dated 5/16/25, indicated to cleanse left heel pressure wound with 0.125% Dakin's solution, cover with collagen with silver dressing, then place ABD pad and secure with Kling daily. During a wound dressing change observation on 7/29/25, at 10:32 a.m. completed by Registered Nurse (RN) Employee E2 and RN Employee E4 assisting, the following observations were made: -RN Employee E2 failed to clean the surface being used to hold supplies after completion of dressing change. -RN Employee E2 and RN Employee E4 failed to utilize gowns (enhanced precautions) during the dressing change as required. During an interview completed on 07/29/25, 10:55 a.m. RN Employee E2 confirmed the failure to utilize gowns as required and failed to clean the surface being used to hold supplies after completion of dressing change and that the facility failed to prevent cross contamination and follow enhanced barrier precaution during a dressing change for one of three residents (Resident R7) Review of the clinical record indicated resident R1 was admitted to the facility on [DATE]. During an interview and observation completed on 7/28/25, at 10:14 a.m. it was revealed that a personal refrigerator was in Resident R1's room. Upon asking Resident R1 concerning the refrigerator monitoring stated I take care of my refrigerator the refrigerator failed to have a thermometer or temperature log. Review of the clinical record indicated resident R67 was admitted to the facility on [DATE]. During an observation completed on 7/28/25, at 9:50 a.m. it was revealed that a personal refrigerator was in Resident R67's room the refrigerator failed to have a thermometer or temperature log. During an interview completed on 7/28/25, at 10:23 a.m. upon asking Licensed Practical Nurse (LPN) Employee E1 concerning the monitoring of resident in room refrigerators stated, I don't think we maintain them, I don't do anything with it and confirmed Resident R1 and Resident R67's personal in room refrigerators failed to have a thermometer or temperature log. Review of the clinical record indicated resident R34 was admitted to the facility on [DATE]. During an interview and observation completed on 7/28/25, at 1:30 p.m. it was revealed that a personal refrigerator was in Resident R34's room. Upon asking Resident R34 concerning the refrigerator monitoring stated, My family takes care of it the refrigerator failed to have a		